

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: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/28/2019 12:26 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/28/2019 Time: 12:26 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN
		10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by KING'S DAUGHTERS' HOSPITAL (15-0069) 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) JOHN PRICE
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-407,416	-62,369	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	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	-407,416	-62,369	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-MEDI CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0069			Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:26 pm				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: ONE KINGS DAUGHTERS DRIVE			PO Box: 447						1.00	
2.00	City: MADISON			State: IN		Zip Code: 47250-		County: JEFFERSON		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		KING'S DAUGHTERS' HOSPITAL	150069	99915	1	06/17/1966	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		KING'S DAUGHTERS' HOSPITAL HHA	157141	99915		03/08/1985	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice		KING'S DAUGHTERS'	151535	99915		09/01/1995				14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2018	12/31/2018		20.00	
21.00	Type of Control (see instructions)						2		21.00		
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		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.			1,018	880	179	33	663	80	24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0069		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:26 pm			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00	
						Urban/Rural	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	10/01/2015	27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					1		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					01/01/2018	12/31/2018	36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								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)			Y				60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)				23.00	1		60.01	

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

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

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						1.00			
Long Term Care Hospital PPS									
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.					N		81.00	
TEFRA Providers									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					N		87.00	
						V	XIX		
						1.00	2.00		
Title V and XIX Services									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.					N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.					N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.06	
Rural Providers									
105.00	Does this hospital qualify as a CAH?					N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					N		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.					N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					N		108.00	
						Physical	Occupational	Speech	Respiratory
						1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					N	N	N	N
						1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.						N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:26 pm		
		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.	N				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.	0				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	1,154,244	0			118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	Y		Y		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)	N				140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:26 pm			
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:			
142.00	Street:	PO Box:					
143.00	City:	State:		Zip Code:			
				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.				N	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)				9.99	169.00	
		Beginning		Ending			
		1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				01/01/2018	12/31/2018	
				1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)				N	0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0069		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 12:26 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/08/2019	Y	03/08/2019		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0069

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

Worksheet S-2
Part II
Date/Time Prepared:
5/28/2019 12:26 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N	N	21.00
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
Interest Expense						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
Purchased Services						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
Provider-Based Physicians						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
Home Office Costs						
36.00	Were home office costs claimed on the cost report?					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.					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.					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.	LUCIA		GERBER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502.992.3524		LGERBER@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 12:26 pm
		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.	SENIOR 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: 15-0069

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2019 12:26 pm

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	82	29,930	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)		82	29,930	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)		88	32,120	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	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	1	365			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)		89			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: 15-0069

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2019 12:26 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,149	1,452	9,445			1.00
2.00 HMO and other (see instructions)	1,259	755				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	5,149	1,452	9,445			7.00
8.00 INTENSIVE CARE UNIT	701	267	1,432			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		299	1,228			13.00
14.00 Total (see instructions)	5,850	2,018	12,105	0.00	763.47	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	4,419	594	7,561	0.00	13.63	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	12	0	12	0.00	1.56	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	778.66	27.00
28.00 Observation Bed Days		521	2,291			28.00
29.00 Ambulance Trips	2,109					29.00
30.00 Employee discount days (see instruction)			104			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	80	138			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: 15-0069

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2019 12:26 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,517	477	3,085	1.00
2.00 HMO and other (see instructions)			296	209		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	1,517	477	3,085	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	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					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: 15-0069

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

Worksheet S-3
Part II
Date/Time Prepared:
5/28/2019 12:26 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	51,891,680	520,172	52,411,852	1,619,614.69	32.36
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		271,996	0	271,996	3,052.50	89.11
4.00	Physician-Part A - Administrative		29,556	0	29,556	175.50	168.41
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		3,158,046	0	3,158,046	13,117.00	240.76
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)		22,055,335	68,377	22,123,712	513,336.59	43.10
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		290,336	0	290,336	6,035.08	48.11
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		797,311	0	797,311	5,428.16	146.88
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		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)		8,005,409	0	8,005,409		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		4,752,757	0	4,752,757		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		42,987	0	42,987		
22.00	Physician Part A - Administrative		4,034	0	4,034		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		390,270	0	390,270		
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	0	0	0	0.00	0.00
27.00	Administrative & General	5.00	6,170,314	520,172	6,690,486	267,062.20	25.05

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0069

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

Worksheet S-3
Part II
Date/Time Prepared:
5/28/2019 12:26 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		471,176	0	471,176	2,215.57	212.67	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	573,359	0	573,359	23,470.80	24.43	30.00
31.00	Laundry & Linen Service	8.00	47,228	0	47,228	4,170.10	11.33	31.00
32.00	Housekeeping	9.00	708,780	0	708,780	58,708.75	12.07	32.00
33.00	Housekeeping under contract (see instructions)		232,888	0	232,888	10,074.56	23.12	33.00
34.00	Dietary	10.00	699,082	-251,304	447,778	29,441.59	15.21	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	251,304	251,304	16,524.00	15.21	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	428,327	0	428,327	11,812.20	36.26	38.00
39.00	Central Services and Supply	14.00	79,264	0	79,264	5,523.45	14.35	39.00
40.00	Pharmacy	15.00	720,881	0	720,881	20,501.43	35.16	40.00
41.00	Medical Records & Medical Records Library	16.00	527,472	0	527,472	24,465.75	21.56	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0069

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

Worksheet S-3
Part III
Date/Time Prepared:
5/28/2019 12:26 pm

	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)	49,165,702	520,172	49,685,874	1,615,735.32	30.75	1.00
2.00	Excluded area salaries (see instructions)	22,055,335	68,377	22,123,712	513,336.59	43.10	2.00
3.00	Subtotal salaries (line 1 minus line 2)	27,110,367	451,795	27,562,162	1,102,398.73	25.00	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,087,647	0	1,087,647	11,463.24	94.88	4.00
5.00	Subtotal wage-related costs (see inst.)	8,009,443	0	8,009,443	0.00	29.06	5.00
6.00	Total (sum of lines 3 thru 5)	36,207,457	451,795	36,659,252	1,113,861.97	32.91	6.00
7.00	Total overhead cost (see instructions)	10,658,771	520,172	11,178,943	473,970.40	23.59	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part IV Date/Time Prepared: 5/28/2019 12:26 pm
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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)	2,005,921	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)	6,686,628	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,079,962	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	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)	216,821	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	3,203,562	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	2,562	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,195,456	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: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part V Date/Time Prepared: 5/28/2019 12:26 pm
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		290,336	13,195,456
2.00	Hospital		290,336	13,195,456
3.00	Subprovider - IPF			
4.00	Subprovider - IRF			
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA		0	0
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice		0	0
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	Renal Dialysis			
18.00	Other		0	0

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0069 Component CCN: 15-7141			Period: From 01/01/2018 To 12/31/2018		Worksheet S-4 Date/Time Prepared: 5/28/2019 12:26 pm		
					Home Health Agency I		PPS		
					1.00				
0.00	County				JEFFERSON		0.00		
		Title V	Title XVIII	Title XIX	Other	Total			
		1.00	2.00	3.00	4.00	5.00			
HOME HEALTH AGENCY STATISTICAL DATA									
1.00	Home Health Aide Hours	0	721	0	649	1,370		1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	321.00	0.00	289.00	610.00		2.00	
					Number of Employees (Full Time Equivalent)				
		Enter the number of hours in your normal work week			Staff	Contract	Total		
		0			1.00	2.00	3.00		
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES									
3.00	Administrator and Assistant Administrator(s)	40.00			0.00	0.00	0.00		3.00
4.00	Director(s) and Assistant Director(s)				0.00	0.00	0.00		4.00
5.00	Other Administrative Personnel				9.92	0.00	9.92		5.00
6.00	Direct Nursing Service				0.04	0.00	0.04		6.00
7.00	Nursing Supervisor				0.00	0.00	0.00		7.00
8.00	Physical Therapy Service				2.65	0.00	2.65		8.00
9.00	Physical Therapy Supervisor				0.00	0.00	0.00		9.00
10.00	Occupational Therapy Service				0.68	0.00	0.68		10.00
11.00	Occupational Therapy Supervisor				0.00	0.00	0.00		11.00
12.00	Speech Pathology Service				0.05	0.00	0.05		12.00
13.00	Speech Pathology Supervisor				0.00	0.00	0.00		13.00
14.00	Medical Social Service				0.00	0.00	0.00		14.00
15.00	Medical Social Service Supervisor				0.00	0.00	0.00		15.00
16.00	Home Health Aide				0.66	0.00	0.66		16.00
17.00	Home Health Aide Supervisor				0.00	0.00	0.00		17.00
18.00	Other (specify)				0.00	0.00	0.00		18.00
HOME HEALTH AGENCY CBSA CODES									
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				1				19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).				99915				20.00
		Full Episodes			LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)		
		Without Outliers	With Outliers						
		1.00	2.00	3.00	4.00	5.00			
PPS ACTIVITY DATA									
21.00	Skilled Nursing Visits	1,697	170	66	34	1,967		21.00	
22.00	Skilled Nursing Visit Charges	397,098	39,780	15,444	7,956	460,278		22.00	
23.00	Physical Therapy Visits	1,762	10	27	82	1,881		23.00	
24.00	Physical Therapy Visit Charges	368,258	2,090	5,643	17,138	393,129		24.00	
25.00	Occupational Therapy Visits	391	5	2	17	415		25.00	
26.00	Occupational Therapy Visit Charges	90,712	1,160	464	3,944	96,280		26.00	
27.00	Speech Pathology Visits	12	0	0	0	12		27.00	
28.00	Speech Pathology Visit Charges	2,868	0	0	0	2,868		28.00	
29.00	Medical Social Service Visits	1	0	0	0	1		29.00	
30.00	Medical Social Service Visit Charges	316	0	0	0	316		30.00	
31.00	Home Health Aide Visits	143	0	0	0	143		31.00	
32.00	Home Health Aide Visit Charges	19,591	0	0	0	19,591		32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,006	185	95	133	4,419		33.00	
34.00	Other Charges	0	0	0	0	0		34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	878,843	43,030	21,551	29,038	972,462		35.00	
36.00	Total Number of Episodes (standard/non outlier)	300		30	13	343		36.00	
37.00	Total Number of Outlier Episodes		5		0	5		37.00	
38.00	Total Non-Routine Medical Supply Charges	0	0	285	0	285		38.00	

HOSPITAL-BASED HOSPI CE IDENTIFICATION DATA		Provider CCN: 15-0069 Hospice CCN: 15-1535	Period: From 01/01/2018 To 12/31/2018	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/28/2019 12:26 pm
		Hospice I		

	Unduplicated Days	Hospice I				Total (sum of cols. 1, 2 & 5)		
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility			All Other
		1.00	2.00	3.00	4.00			5.00
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
1.00	Hospice Continuous Home Care						1.00	
2.00	Hospice Routine Home Care						2.00	
3.00	Hospice Inpatient Respite Care						3.00	
4.00	Hospice General Inpatient Care						4.00	
5.00	Total Hospice Days						5.00	
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
6.00	Number of patients receiving hospice care						6.00	
7.00	Total number of unduplicated Continuous Care hours billable to Medicare						7.00	
8.00	Average Length of Stay (line 5 / line 6)						8.00	
9.00	Unduplicated census count						9.00	

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	1,306	160	147	1,613	11.00
12.00	Hospice Inpatient Respite Care	5	0	0	5	12.00
13.00	Hospice General Inpatient Care	7	0	0	7	13.00
14.00	Total Hospice Days	1,318	160	147	1,625	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/28/2019 12:26 pm
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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)		0.239357	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		10,909,304	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		46,103,224	6.00	
7.00	Medicaid cost (line 1 times line 6)		11,035,129	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)		125,825	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)		125,825	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)	2,625,741	91,363	2,717,104	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	628,489	91,363	719,852	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	628,489	91,363	719,852	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)		9,357,567	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		230,388	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		354,444	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		9,003,123	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,279,017	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,998,869	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,124,694	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0069

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

Worksheet A
Date/Time Prepared:
5/28/2019 12:26 pm

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		14,052,395	14,052,395	245,100	14,297,495	1.00
1.01	00101			0	7,887	7,887	1.01
2.00	00200		0	0	0	0	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	0	14,395,369	14,395,369	-252,987	14,142,382	4.00
5.00	00500	6,170,314	10,699,037	16,869,351	-358,020	16,511,331	5.00
7.00	00700	573,359	2,434,649	3,008,008	-26	3,007,982	7.00
8.00	00800	47,228	295,207	342,435	0	342,435	8.00
9.00	00900	708,780	421,418	1,130,198	0	1,130,198	9.00
10.00	01000	699,082	416,821	1,115,903	-401,142	714,761	10.00
11.00	01100	0	0	0	401,142	401,142	11.00
13.00	01300	428,327	1,710	430,037	0	430,037	13.00
14.00	01400	79,264	1,360	80,624	0	80,624	14.00
15.00	01500	720,881	7,683,383	8,404,264	-7,057,434	1,346,830	15.00
16.00	01600	527,472	332,960	860,432	0	860,432	16.00
19.00	01900	0	0	0	271,996	271,996	19.00
23.00	02300	123,446	9,144	132,590	0	132,590	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,800,393	1,071,840	5,872,233	-1,392,564	4,479,669	30.00
31.00	03100	1,058,638	12,624	1,071,262	-607	1,070,655	31.00
43.00	04300	0	0	0	513,110	513,110	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,939,965	8,524,239	10,464,204	-7,779,050	2,685,154	50.00
51.00	05100	288,550	31,704	320,254	-24,774	295,480	51.00
52.00	05200	0	0	0	479,379	479,379	52.00
53.00	05300	1,446,625	1,218,740	2,665,365	-395,266	2,270,099	53.00
54.00	05400	2,765,678	1,036,083	3,801,761	-25,722	3,776,039	54.00
54.01	03630	121,855	28,411	150,266	-1,990	148,276	54.01
54.02	03450	66,188	204,824	271,012	-4,089	266,923	54.02
55.00	03480	837,829	1,538,064	2,375,893	-57,806	2,318,087	55.00
57.00	05700	170,468	285,153	455,621	-12,766	442,855	57.00
58.00	05800	131,504	129,704	261,208	-843	260,365	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,489,508	3,104,471	4,593,979	-1,538,230	3,055,749	60.00
62.00	06200	0	274,821	274,821	0	274,821	62.00
65.00	06500	602,708	120,148	722,856	-86,213	636,643	65.00
66.00	06600	1,347,054	47,082	1,394,136	-75,362	1,318,774	66.00
67.00	06700	196,223	7,348	203,571	-3,254	200,317	67.00
68.00	06800	153,470	3,506	156,976	-1,809	155,167	68.00
69.00	06900	0	0	0	0	0	69.00
69.01	03610	139,011	81,372	220,383	-5,613	214,770	69.01
71.00	07100	0	0	0	2,938,948	2,938,948	71.00
71.01	07101	0	0	0	127,073	127,073	71.01
72.00	07200	0	0	0	5,872,363	5,872,363	72.00
73.00	07300	0	0	0	8,538,718	8,538,718	73.00
76.00	03140	436,700	232,812	669,512	-24,118	645,394	76.00
76.97	07697	69,977	5,355	75,332	-390	74,942	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	111,314	17,002	128,316	-12,530	115,786	90.00
91.00	09100	1,707,980	940,550	2,648,530	-230,887	2,417,643	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	1,468,829	213,034	1,681,863	-47,119	1,634,744	95.00
101.00	10100	869,676	96,097	965,773	7,888	973,661	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		0	0	0	0	113.00
116.00	11600	45,558	69,188	114,746	47,022	161,768	116.00
118.00		32,343,854	70,037,625	102,381,479	-339,985	102,041,494	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	2,172,011	365,252	2,537,263	0	2,537,263	194.01
194.02	07952	5,155,890	1,491,222	6,647,112	-43,752	6,603,360	194.02
194.03	07953	670,989	10,585	681,574	831,085	1,512,659	194.03
194.04	07954	389,029	-3,586	385,443	0	385,443	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	3,220,414	296,306	3,516,720	-145,648	3,371,072	194.06
194.07	07957	4,039,057	416,927	4,455,984	-208,069	4,247,915	194.07
194.08	07958	1,370,313	231,068	1,601,381	0	1,601,381	194.08
194.09	07959	652,815	24,743	677,558	-78,026	599,532	194.09
194.10	07960	96,052	495,275	591,327	0	591,327	194.10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0069		Period: From 01/01/2018 To 12/31/2018	Worksheet A Date/Time Prepared: 5/28/2019 12:26 pm		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
194.11	07961 KDH - MC OB/GYN	1,781,256	581,827	2,363,083	-15,605	2,347,478	194.11
200.00	TOTAL (SUM OF LINES 118 through 199)	51,891,680	73,947,244	125,838,924	0	125,838,924	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0069

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

Worksheet A
Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-1,720,685	12,576,810	1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	7,887	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,241,494	12,900,888	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,411,291	12,100,040	5.00
7.00	00700	OPERATION OF PLANT	-23,320	2,984,662	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	342,435	8.00
9.00	00900	HOUSEKEEPING	0	1,130,198	9.00
10.00	01000	DIETARY	0	714,761	10.00
11.00	01100	CAFETERIA	-414,193	-13,051	11.00
13.00	01300	NURSING ADMINISTRATION	0	430,037	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	80,624	14.00
15.00	01500	PHARMACY	0	1,346,830	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-52	860,380	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-271,996	0	19.00
23.00	02300	RADIOLOGY SCHOOL	-45,275	87,315	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-742,638	3,737,031	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,070,655	31.00
43.00	04300	NURSERY	0	513,110	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,685,154	50.00
51.00	05100	RECOVERY ROOM	-57,606	237,874	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	479,379	52.00
53.00	05300	ANESTHESIOLOGY	-2,390,793	-120,694	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,857,383	1,918,656	54.00
54.01	03630	ULTRA SOUND	0	148,276	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	266,923	54.02
55.00	03480	ONCOLOGY	-756,367	1,561,720	55.00
57.00	05700	CT SCAN	-203,800	239,055	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	260,365	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-49,047	3,006,702	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	274,821	62.00
65.00	06500	RESPIRATORY THERAPY	0	636,643	65.00
66.00	06600	PHYSICAL THERAPY	0	1,318,774	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	200,317	67.00
68.00	06800	SPEECH PATHOLOGY	0	155,167	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03610	SLEEP LAB	0	214,770	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-6	2,938,942	71.00
71.01	07101	IV SOLUTIONS	0	127,073	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,872,363	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,538,718	73.00
76.00	03140	CARDIOLOGY	0	645,394	76.00
76.97	07697	CARDIAC REHABILITATION	0	74,942	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	115,786	90.00
91.00	09100	EMERGENCY	-295,420	2,122,223	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-600	1,634,144	95.00
101.00	10100	HOME HEALTH AGENCY	0	973,661	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	161,768	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-14,481,966	87,559,528	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	194.00
194.01	07951	MOB	0	2,537,263	194.01
194.02	07952	PHYSICIAN CLINICS	0	6,603,360	194.02
194.03	07953	PHYS PRAC BUS OFC	0	1,512,659	194.03
194.04	07954	MOB - MAIN CAMPUS	0	385,443	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	3,371,072	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	4,247,915	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	1,601,381	194.08
194.09	07959	KDH - MC ENT	0	599,532	194.09
194.10	07960	KDH - MC UROLOGY	0	591,327	194.10
194.11	07961	KDH - MC OB/GYN	0	2,347,478	194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	-14,481,966	111,356,958	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	251,304	149,838	1.00
	O		251,304	149,838	
B - MEDICAL IMAGING TIME					
1.00	PHYSICIAN CLINICS	194.02	13,467	0	1.00
	O		13,467	0	
C - DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	1.01	0	7,887	1.00
	O		0	7,887	
D - NURSERY- L&D					
1.00	NURSERY	43.00	498,311	14,799	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	465,553	13,826	2.00
	O		963,864	28,625	
E - CRNA EXPENSE					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	271,996	0	1.00
	O		271,996	0	
F - PHYSICIAN BILLING AND COLLECTIONS					
1.00	PHYS PRAC BUS OFC	194.03	0	831,085	1.00
	O		0	831,085	
G - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	520,172	0	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
	O		520,172	0	
I - MED/SURG SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,938,948	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
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	O		0	2,938,948	
J - IV SOLUTIONS					
1.00	IV SOLUTIONS	71.01	0	127,073	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
	O		0	127,073	
K - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,872,363	1.00
	O		0	5,872,363	
L - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	8,538,718	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00

Provider CCN: 15-0069

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

Worksheet A-6
Date/Time Prepared:
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Increases						
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
				8,538,718		
M - INSURANCE						
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	252,987		1.00
			0	252,987		
N - HOME HEALTH DIRECTOR						
1.00	HOME HEALTH AGENCY	101.00	54,910	0		1.00
	TOTALS		54,910	0		
O - HOSPICE						
1.00	HOSPICE	116.00	47,022	0		1.00
	TOTALS		47,022	0		
500.00	Grand Total : Increases		2,122,735	18,747,524		500.00

RECLASSIFICATIONS

Provider CCN: 15-0069

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

Worksheet A-6
Date/Time Prepared:
5/28/2019 12:26 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	251,304	149,838	0		1.00
	O		251,304	149,838			
B - MEDICAL IMAGING TIME							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	13,467	0	0		1.00
	O		13,467	0			
C - DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	7,887	9		1.00
	O		0	7,887			
D - NURSERY- L&D							
1.00	ADULTS & PEDIATRICS	30.00	963,864	28,625	0		1.00
2.00	O	0.00	0	0	0		2.00
			963,864	28,625			
E - CRNA EXPENSE							
1.00	ANESTHESIOLOGY	53.00	271,996	0	0		1.00
	O		271,996	0			
F - PHYSICIAN BILLING AND COLLECTIONS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	831,085	0		1.00
	O		0	831,085			
G - EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,605	0		1.00
2.00	PHYSICIAN CLINICS	194.02	0	57,219	0		2.00
3.00	KDH - MC FAMILY PRACTICE	194.06	0	145,648	0		3.00
4.00	KDH - MC ORTHOPEDICS	194.07	0	208,069	0		4.00
5.00	KDH - MC ENT	194.09	0	78,026	0		5.00
6.00	KDH - MC OB/GYN	194.11	0	15,605	0		6.00
	O		0	520,172			
I - MED/SURG SUPPLIES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,369	0		1.00
2.00	OPERATION OF PLANT	7.00	0	26	0		2.00
3.00	PHARMACY	15.00	0	9,342	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	381,135	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	607	0		5.00
6.00	OPERATING ROOM	50.00	0	1,879,107	0		6.00
7.00	RECOVERY ROOM	51.00	0	24,129	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	79,865	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,122	0		9.00
10.00	ULTRA SOUND	54.01	0	1,715	0		10.00
11.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	0	1,245	0		11.00
12.00	ONCOLOGY	55.00	0	55,743	0		12.00
13.00	CT SCAN	57.00	0	12,766	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	843	0		14.00
15.00	LABORATORY	60.00	0	117,719	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	49,609	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	15,375	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	3,254	0		18.00
19.00	SPEECH PATHOLOGY	68.00	0	1,809	0		19.00
20.00	SLEEP LAB	69.01	0	5,613	0		20.00
21.00	CARDIOLOGY	76.00	0	24,118	0		21.00
22.00	CARDIAC REHABILITATION	76.97	0	390	0		22.00
23.00	CLINIC	90.00	0	12,530	0		23.00
24.00	EMERGENCY	91.00	0	219,611	0		24.00
25.00	AMBULANCE SERVICES	95.00	0	35,906	0		25.00
	O		0	2,938,948			
J - IV SOLUTIONS							
1.00	PHARMACY	15.00	0	65,918	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	18,940	0		2.00
3.00	OPERATING ROOM	50.00	0	27,580	0		3.00
4.00	RECOVERY ROOM	51.00	0	645	0		4.00
5.00	ONCOLOGY	55.00	0	2,063	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	18	0		6.00
7.00	EMERGENCY	91.00	0	11,276	0		7.00
8.00	AMBULANCE SERVICES	95.00	0	633	0		8.00
	O		0	127,073			
K - IMPLANTS							
1.00	OPERATING ROOM	50.00	0	5,872,363	0		1.00
	O		0	5,872,363			
L - DRUGS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	30,133	0		1.00
2.00	PHARMACY	15.00	0	6,982,174	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	43,405	0		3.00

RECLASSIFICATIONS

Provider CCN: 15-0069

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

Worksheet A-6

Date/Time Prepared:
5/28/2019 12:26 pm

Decreases								
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,133	0		4.00	
5.00	ULTRA SOUND	54.01	0	275	0		5.00	
6.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	0	2,844	0		6.00	
7.00	LABORATORY	60.00	0	1,420,511	0		7.00	
8.00	PHYSICAL THERAPY	66.00	0	5,077	0		8.00	
9.00	RESPIRATORY THERAPY	65.00	0	36,586	0		9.00	
10.00	AMBULANCE SERVICES	95.00	0	10,580	0		10.00	
			0	8,538,718				
M - INSURANCE								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	252,987	12		1.00	
			0	252,987				
N - HOME HEALTH DIRECTOR								
1.00	PHYSICAL THERAPY	66.00	54,910	0	0		1.00	
	TOTALS		54,910	0				
O - HOSPICE								
1.00	HOME HEALTH AGENCY	101.00	47,022	0	0		1.00	
	TOTALS		47,022	0				
500.00	Grand Total: Decreases		1,602,563	19,267,696			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0069

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

Worksheet A-7
Part I
Date/Time Prepared:
5/28/2019 12:26 pm

		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	3,499,119	0	0	0	0	1.00
2.00	Land Improvements	546,799	0	0	0	6,143	2.00
3.00	Buildings and Fixtures	117,987,460	0	0	0	33,542	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	63,666,718	2,276,435	0	2,276,435	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	185,700,096	2,276,435	0	2,276,435	39,685	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	185,700,096	2,276,435	0	2,276,435	39,685	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,499,119	0				1.00
2.00	Land Improvements	540,656	0				2.00
3.00	Buildings and Fixtures	117,953,918	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	65,943,153	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	187,936,846	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	187,936,846	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0069

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

Worksheet A-7
Part II
Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	8,694,756	65,799	5,280,032	0	11,808	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,694,756	65,799	5,280,032	0	11,808	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	NEW CAP REL COSTS-BLDG & FIXT	0	14,052,395				1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	14,052,395				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0069

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

Worksheet A-7
Part III
Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	121,993,693	0	121,993,693	0.649121	0	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	65,943,153	0	65,943,153	0.350879	0	2.00
3.00	Total (sum of lines 1-2)	187,936,846	0	187,936,846	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	8,686,869	45,579	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	7,887	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	8,694,756	45,579	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,579,567	252,987	11,808	0	12,576,810	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	0	7,887	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,579,567	252,987	11,808	0	12,584,697	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-171,052	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01 Investment income - NEW CAP REL COSTS-BLDG & FIXT HHA/HO (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT HHA/HO	1.01	0	1.01
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	B	-20,220	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-4,533	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-23,320	OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-6,633,044			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-414,193	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	B	-6	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	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	-52	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		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)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01 Depreciation - NEW CAP REL COSTS-BLDG & FIXT HHA/HO			NEW CAP REL COSTS-BLDG & FIXT HHA/HO	1.01	0	26.01
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist	A	-271,996	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 RADIOLOGY TUITION	B	-45,275		RADIOLOGY SCHOOL	23.00	0	33.00
33.01 COPIER BUYOUT REVENUE	B	-57,606		RECOVERY ROOM	51.00	0	33.01
33.02 AMBULANCE REVENUE	B	-391		AMBULANCE SERVICES	95.00	0	33.02
33.03 ADVERTISING	A	-232,175		ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 SELF-INSURANCE	A	-1,178,730		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05 HOSPITAL ASSOCIATION FEES	A	-8,582		ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06 HAF MEDICAID	A	-3,391,276		ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 PHYSICIAN RECRUITMENT	A	-370,500		ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08 PHYSICIAN LAB SALARY OFFSET	A	-49,047		LABORATORY	60.00	0	33.08
33.09 PHYSICIAN LAB BENEFIT OFFSET	A	-9,589		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10 CRNA BENEFIT OFFSET	A	-53,175		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11 DONATIONS	A	-17,791		ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12 REALIZED GAIN/LOSS	B	-1,529,413		NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.12
33.13 OTHER ADJUSTMENTS (SPECIFY (3))		0			0.00	0	33.13
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-14,481,966					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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0069

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

Worksheet A-8-2

Date/Time Prepared:
5/28/2019 12:26 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	386,434	386,434	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	742,638	742,638	0	211,500	0	2.00
3.00	53.00	ANESTHESIOLOGY	2,393,786	2,373,769	20,017	239,400	26	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	1,857,383	1,857,383	0	271,900	0	4.00
5.00	55.00	ONCOLOGY	768,796	756,367	12,429	211,500	141	5.00
6.00	57.00	CT SCAN	203,800	203,800	0	211,500	0	6.00
7.00	60.00	LABORATORY	150,000	0	150,000	260,300	1,946	7.00
8.00	69.01	SLEEP LAB	14,346	0	14,346	211,500	143	8.00
9.00	91.00	EMERGENCY	635,854	0	635,854	211,500	3,348	9.00
10.00	95.00	AMBULANCE SERVICES	717	0	717	211,500	5	10.00
200.00			7,153,754	6,320,391	833,363		5,609	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	2,993	150	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	55.00	ONCOLOGY	14,337	717	0	0	0	5.00
6.00	57.00	CT SCAN	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	243,531	12,177	0	0	0	7.00
8.00	69.01	SLEEP LAB	14,541	727	0	0	0	8.00
9.00	91.00	EMERGENCY	340,434	17,022	0	0	0	9.00
10.00	95.00	AMBULANCE SERVICES	508	25	0	0	0	10.00
200.00			616,344	30,818	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	386,434	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	742,638	2.00
3.00	53.00	ANESTHESIOLOGY	0	2,993	17,024	2,390,793	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,857,383	4.00
5.00	55.00	ONCOLOGY	0	14,337	0	756,367	5.00
6.00	57.00	CT SCAN	0	0	0	203,800	6.00
7.00	60.00	LABORATORY	0	243,531	0	0	7.00
8.00	69.01	SLEEP LAB	0	14,541	0	0	8.00
9.00	91.00	EMERGENCY	0	340,434	295,420	295,420	9.00
10.00	95.00	AMBULANCE SERVICES	0	508	209	209	10.00
200.00			0	616,344	312,653	6,633,044	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	12,576,810	12,576,810			1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	7,887	0	7,887		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0			0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,900,888	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,100,040	1,478,789	0	0	5.00
7.00	00700	OPERATION OF PLANT	2,984,662	1,397,261	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	342,435	64,774	0	0	8.00
9.00	00900	HOUSEKEEPING	1,130,198	113,541	0	0	9.00
10.00	01000	DIETARY	714,761	213,863	0	0	10.00
11.00	01100	CAFETERIA	-13,051	86,490	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	430,037	69,260	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	80,624	105,215	0	0	14.00
15.00	01500	PHARMACY	1,346,830	78,198	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	860,380	9,923	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00	02300	RADIOLOGY SCHOOL	87,315	22,464	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,737,031	1,352,640	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,070,655	56,890	0	0	31.00
43.00	04300	NURSERY	513,110	66,439	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,685,154	626,533	0	0	50.00
51.00	05100	RECOVERY ROOM	237,874	46,728	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	479,379	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-120,694	4,418	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,918,656	368,423	0	0	54.00
54.01	03630	ULTRA SOUND	148,276	0	0	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	266,923	16,414	0	0	54.02
55.00	03480	ONCOLOGY	1,561,720	416,205	0	0	55.00
57.00	05700	CT SCAN	239,055	30,416	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	260,365	36,703	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	3,006,702	212,028	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	274,821	9,482	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	636,643	40,679	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,318,774	421,438	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	200,317	48,258	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	155,167	11,419	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03610	SLEEP LAB	214,770	28,513	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,938,942	0	0	0	71.00
71.01	07101	I.V. SOLUTIONS	127,073	0	0	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,872,363	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,538,718	0	0	0	73.00
76.00	03140	CARDIOLOGY	645,394	205,503	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	74,942	23,891	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	115,786	29,566	0	0	90.00
91.00	09100	EMERGENCY	2,122,223	471,667	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,634,144	160,813	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	973,661	0	6,207	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	161,768	0	1,680	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,559,528	8,324,844	7,887	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	25,556	0	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07951	MOB	2,537,263	1,788,757	0	0	194.01
194.02	07952	PHYSICIAN CLINICS	6,603,360	937,760	0	0	194.02
194.03	07953	PHYS PRAC BUS OFC	1,512,659	33,610	0	0	194.03
194.04	07954	MOB - MAIN CAMPUS	385,443	0	0	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	3,371,072	1,466,283	0	0	194.06
194.07	07957	KDH - MC ORTHOPEDICS	4,247,915	0	0	0	194.07
194.08	07958	KDH - MC GENERAL SURGERY	1,601,381	0	0	0	194.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP		
		0	1.00	1.01		
194.09 07959 KDH - MC ENT	599,532	0	0	0	143,789	194.09
194.10 07960 KDH - MC UROLOGY	591,327	0	0	0	24,028	194.10
194.11 07961 KDH - MC OB/GYN	2,347,478	0	0	0	441,695	194.11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	111,356,958	12,576,810	7,887	0	12,900,888	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

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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	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,248,599	15,248,599			5.00
7.00	00700	OPERATION OF PLANT	4,525,354	717,993	5,243,347		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	419,024	66,482	34,588	520,094	8.00
9.00	00900	HOUSEKEEPING	1,421,047	225,463	60,628	0	1,707,138
10.00	01000	DIETARY	1,040,640	165,108	114,198	0	0
11.00	01100	CAFETERIA	136,305	21,626	46,184	0	0
13.00	01300	NURSING ADMINISTRATION	606,447	96,219	36,983	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	205,668	32,631	56,182	0	16,030
15.00	01500	PHARMACY	1,605,364	254,707	41,756	0	32,199
16.00	01600	MEDICAL RECORDS & LIBRARY	1,002,255	159,018	5,299	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
23.00	02300	RADIOLOGY SCHOOL	140,660	22,317	11,995	0	3,415
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,049,417	959,801	722,278	161,585	831,075
31.00	03100	INTENSIVE CARE UNIT	1,392,374	220,914	30,378	0	46,870
43.00	04300	NURSERY	704,206	111,729	35,477	11,411	7,771
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,796,989	602,430	334,554	103,407	88,582
51.00	05100	RECOVERY ROOM	356,786	56,608	24,952	13,433	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	595,842	94,536	0	10,662	35,022
53.00	05300	ANESTHESIOLOGY	177,569	28,173	2,359	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,975,572	472,104	196,729	32,299	55,547
54.01	03630	ULTRA SOUND	178,759	28,362	0	3,602	14,462
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	299,895	47,581	8,765	2,160	4,007
55.00	03480	ONCOLOGY	2,187,516	347,071	222,244	15,370	106,145
57.00	05700	CT SCAN	312,115	49,520	16,241	16,211	5,889
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	329,965	52,352	19,599	3,600	4,983
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	3,579,076	567,856	113,218	0	57,498
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	284,303	45,108	5,063	0	0
65.00	06500	RESPIRATORY THERAPY	828,095	131,386	21,722	0	0
66.00	06600	PHYSICAL THERAPY	2,063,455	327,388	225,038	22,627	23,522
67.00	06700	OCCUPATIONAL THERAPY	297,662	47,227	25,768	0	0
68.00	06800	SPEECH PATHOLOGY	204,978	32,522	6,097	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
69.01	03610	SLEEP LAB	278,058	44,117	15,225	1,904	22,860
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,938,942	466,293	0	0	0
71.01	07101	IV SOLUTIONS	127,073	20,161	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,872,363	931,709	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	8,538,718	1,354,753	0	0	0
76.00	03140	CARDIOLOGY	960,142	152,336	109,734	18,081	7,004
76.97	07697	CARDIAC REHABILITATION	116,338	18,458	12,757	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	173,198	27,480	15,788	4	6,795
91.00	09100	EMERGENCY	3,021,158	479,337	251,859	85,558	123,395
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,162,399	343,086	85,871	10,087	0
101.00	10100	HOME HEALTH AGENCY	1,199,399	190,297	49,867	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	186,608	29,607	13,501	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	78,540,333	10,041,866	2,972,897	512,001	1,493,071
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	25,556	4,055	13,646	0	0
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0
194.01	07951	MOB	4,869,370	772,574	955,154	1,010	0
194.02	07952	PHYSICIAN CLINICS	8,819,972	1,399,425	500,742	2,523	0
194.03	07953	PHYS PRAC BUS OFC	1,714,124	271,963	17,947	0	0
194.04	07954	MOB - MAIN CAMPUS	482,762	76,595	0	0	214,067
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	0
194.06	07956	KDH - MC FAMILY PRACTICE	5,606,538	889,533	782,961	59	0
194.07	07957	KDH - MC ORTHOPEDICS	5,206,275	826,028	0	738	0
194.08	07958	KDH - MC GENERAL SURGERY	1,944,179	308,463	0	1,642	0
194.09	07959	KDH - MC ENT	743,321	117,935	0	0	0
194.10	07960	KDH - MC UROLOGY	615,355	97,632	0	0	0
194.11	07961	KDH - MC OB/GYN	2,789,173	442,530	0	2,121	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0069			Period: From 01/01/2018 To 12/31/2018		Worksheet B Part I Date/Time Prepared: 5/28/2019 12:26 pm	
Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
	4A		5.00	7.00	8.00	9.00		
202.00	TOTAL (sum lines 118 through 201)	111,356,958	15,248,599	5,243,347	520,094	1,707,138	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

Period:
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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	1,319,946					10.00
11.00	01100	0	204,115				11.00
13.00	01300	0	0	739,649			13.00
14.00	01400	0	1,463	0	311,974		14.00
15.00	01500	0	5,430	0	846	1,940,302	15.00
16.00	01600	0	6,480	0	186	0	16.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	1,166	0	20	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,214,240	38,267	299,481	4,252	0	30.00
31.00	03100	105,706	8,013	62,706	0	0	31.00
43.00	04300	0	4,044	31,652	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	20,320	159,023	7,047	0	50.00
51.00	05100	0	2,222	17,390	116	0	51.00
52.00	05200	0	3,779	29,573	0	0	52.00
53.00	05300	0	1,654	0	576	0	53.00
54.00	05400	0	14,824	0	1,437	0	54.00
54.01	03630	0	854	0	672	0	54.01
54.02	03450	0	631	0	107	0	54.02
55.00	03480	0	6,939	0	1,445	0	55.00
57.00	05700	0	1,657	0	3,631	0	57.00
58.00	05800	0	1,038	0	539	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	19,938	0	1,095	0	60.00
62.00	06200	0	0	0	0	0	62.00
65.00	06500	0	5,886	0	141	0	65.00
66.00	06600	0	12,351	0	331	0	66.00
67.00	06700	0	1,284	0	0	0	67.00
68.00	06800	0	1,081	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
69.01	03610	0	965	0	5	0	69.01
71.00	07100	0	0	0	90,764	0	71.00
71.01	07101	0	0	0	3,924	0	71.01
72.00	07200	0	0	0	181,356	0	72.00
73.00	07300	0	0	0	1,202	1,940,302	73.00
76.00	03140	0	4,661	0	150	0	76.00
76.97	07697	0	804	0	7	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	828	0	11	0	90.00
91.00	09100	0	17,867	139,824	1,255	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	19,669	0	206	0	95.00
101.00	10100	0	0	0	793	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
116.00	11600	0	0	0	0	0	116.00
118.00		1,319,946	204,115	739,649	302,114	1,940,302	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	632	0	194.01
194.02	07952	0	0	0	2,215	0	194.02
194.03	07953	0	0	0	274	0	194.03
194.04	07954	0	0	0	225	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	617	0	194.06
194.07	07957	0	0	0	3,133	0	194.07
194.08	07958	0	0	0	1,313	0	194.08
194.09	07959	0	0	0	182	0	194.09
194.10	07960	0	0	0	626	0	194.10
194.11	07961	0	0	0	643	0	194.11
200.00							200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,319,946	204,115	739,649	311,974	1,940,302	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

Period:
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Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	RADIOLOGY SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	19.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00	00200	NEW 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	1,173,238				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
23.00	02300	RADIOLOGY SCHOOL	0	179,573			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	36,486	0	0	10,316,882	30.00
31.00	03100	INTENSIVE CARE UNIT	12,174	0	0	1,879,135	31.00
43.00	04300	NURSERY	6,297	0	0	912,587	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	119,351	0	0	5,231,703	50.00
51.00	05100	RECOVERY ROOM	24,317	0	0	495,824	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,775	0	0	775,189	52.00
53.00	05300	ANESTHESIOLOGY	25,157	0	0	235,488	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,556	0	179,573	3,954,641	54.00
54.01	03630	ULTRA SOUND	7,359	0	0	234,070	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	21,613	0	0	384,759	54.02
55.00	03480	ONCOLOGY	24,743	0	0	2,911,473	55.00
57.00	05700	CT SCAN	61,474	0	0	466,738	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,653	0	0	427,729	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	120,548	0	0	4,459,229	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,218	0	0	341,692	62.00
65.00	06500	RESPIRATORY THERAPY	28,720	0	0	1,015,950	65.00
66.00	06600	PHYSICAL THERAPY	36,000	0	0	2,710,712	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,355	0	0	376,296	67.00
68.00	06800	SPEECH PATHOLOGY	3,475	0	0	248,153	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03610	SLEEP LAB	6,717	0	0	369,851	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	52,876	0	0	3,548,875	71.00
71.01	07101	IV SOLUTIONS	8,881	0	0	160,039	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	84,125	0	0	7,069,553	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	268,623	0	0	12,103,598	73.00
76.00	03140	CARDIOLOGY	41,490	0	0	1,293,598	76.00
76.97	07697	CARDIAC REHABILITATION	2,351	0	0	150,715	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	545	0	0	224,649	90.00
91.00	09100	EMERGENCY	99,404	0	0	4,219,657	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	20,955	0	0	2,642,273	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,440,356	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0		0	229,716	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,173,238	0	179,573	70,831,130	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	43,257	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	6,598,740	194.01
194.02	07952	PHYSICIAN CLINICS	0	0	0	10,724,877	194.02
194.03	07953	PHYS PRAC BUS OFC	0	0	0	2,004,308	194.03
194.04	07954	MOB - MAIN CAMPUS	0	0	0	773,649	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	0	0	7,279,708	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	0	0	6,036,174	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	0	0	2,255,597	194.08
194.09	07959	KDH - MC ENT	0	0	0	861,438	194.09
194.10	07960	KDH - MC UROLOGY	0	0	0	713,613	194.10

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	RADIOLOGY SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
			16.00	19.00	23.00	24.00	25.00
194.11	07961	KDH - MC OB/GYN	0	0	0	3,234,467	0
200.00		Cross Foot Adjustments		0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,173,238	0	179,573	111,356,958	0

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO		1.01
2.00	00200 NEW 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
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
23.00	02300 RADIOLOGY SCHOOL		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	10,316,882	30.00
31.00	03100 INTENSIVE CARE UNIT	1,879,135	31.00
43.00	04300 NURSERY	912,587	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	5,231,703	50.00
51.00	05100 RECOVERY ROOM	495,824	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	775,189	52.00
53.00	05300 ANESTHESIOLOGY	235,488	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,954,641	54.00
54.01	03630 ULTRA SOUND	234,070	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	384,759	54.02
55.00	03480 ONCOLOGY	2,911,473	55.00
57.00	05700 CT SCAN	466,738	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	427,729	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	4,459,229	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	341,692	62.00
65.00	06500 RESPIRATORY THERAPY	1,015,950	65.00
66.00	06600 PHYSICAL THERAPY	2,710,712	66.00
67.00	06700 OCCUPATIONAL THERAPY	376,296	67.00
68.00	06800 SPEECH PATHOLOGY	248,153	68.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
69.01	03610 SLEEP LAB	369,851	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,548,875	71.00
71.01	07101 IV SOLUTIONS	160,039	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7,069,553	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,103,598	73.00
76.00	03140 RADIOLOGY	1,293,598	76.00
76.97	07697 CARDIAC REHABILITATION	150,715	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	224,649	90.00
91.00	09100 EMERGENCY	4,219,657	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	2,642,273	95.00
101.00	10100 HOME HEALTH AGENCY	1,440,356	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
116.00	11600 HOSPICE	229,716	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	70,831,130	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	43,257	190.00
194.00	07950 OTHER NON-REIMBURSABLE	0	194.00
194.01	07951 MOB	6,598,740	194.01
194.02	07952 PHYSICIAN CLINICS	10,724,877	194.02
194.03	07953 PHYS PRAC BUS OFC	2,004,308	194.03
194.04	07954 MOB - MAIN CAMPUS	773,649	194.04
194.05	07955 ONCOLOGY - NONREIMBURSABLE	0	194.05
194.06	07956 KDH - MC FAMILY PRACTICE	7,279,708	194.06
194.07	07957 KDH - MC ORTHOPEDICS	6,036,174	194.07
194.08	07958 KDH - MC GENERAL SURGERY	2,255,597	194.08
194.09	07959 KDH - MC ENT	861,438	194.09
194.10	07960 KDH - MC UROLOGY	713,613	194.10
194.11	07961 KDH - MC OB/GYN	3,234,467	194.11
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	111,356,958	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0069

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

Worksheet B
Part II
Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP		
			1.00	1.01	2.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,478,789	0	0	1,478,789
7.00	00700	OPERATION OF PLANT	0	1,397,261	0	0	1,397,261
8.00	00800	LAUNDRY & LINEN SERVICE	0	64,774	0	0	64,774
9.00	00900	HOUSEKEEPING	0	113,541	0	0	113,541
10.00	01000	DIETARY	0	213,863	0	0	213,863
11.00	01100	CAFETERIA	0	86,490	0	0	86,490
13.00	01300	NURSING ADMINISTRATION	0	69,260	0	0	69,260
14.00	01400	CENTRAL SERVICES & SUPPLY	0	105,215	0	0	105,215
15.00	01500	PHARMACY	0	78,198	0	0	78,198
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,923	0	0	9,923
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00	02300	RADIOLOGY SCHOOL	0	22,464	0	0	22,464
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,352,640	0	0	1,352,640
31.00	03100	INTENSIVE CARE UNIT	0	56,890	0	0	56,890
43.00	04300	NURSERY	0	66,439	0	0	66,439
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	626,533	0	0	626,533
51.00	05100	RECOVERY ROOM	0	46,728	0	0	46,728
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	4,418	0	0	4,418
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	368,423	0	0	368,423
54.01	03630	ULTRA SOUND	0	0	0	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	16,414	0	0	16,414
55.00	03480	ONCOLOGY	0	416,205	0	0	416,205
57.00	05700	CT SCAN	0	30,416	0	0	30,416
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	36,703	0	0	36,703
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	212,028	0	0	212,028
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	9,482	0	0	9,482
65.00	06500	RESPIRATORY THERAPY	0	40,679	0	0	40,679
66.00	06600	PHYSICAL THERAPY	0	421,438	0	0	421,438
67.00	06700	OCCUPATIONAL THERAPY	0	48,258	0	0	48,258
68.00	06800	SPEECH PATHOLOGY	0	11,419	0	0	11,419
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03610	SLEEP LAB	0	28,513	0	0	28,513
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
71.01	07101	IV SOLUTIONS	0	0	0	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	205,503	0	0	205,503
76.97	07697	CARDIAC REHABILITATION	0	23,891	0	0	23,891
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	29,566	0	0	29,566
91.00	09100	EMERGENCY	0	471,667	0	0	471,667
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	160,813	0	0	160,813
101.00	10100	HOME HEALTH AGENCY	0	0	6,207	0	6,207
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	1,680	0	1,680
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	8,324,844	7,887	0	8,332,731
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	25,556	0	0	25,556
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07951	MOB	0	1,788,757	0	0	1,788,757
194.02	07952	PHYSICIAN CLINICS	0	937,760	0	0	937,760
194.03	07953	PHYS PRAC BUS OFC	0	33,610	0	0	33,610
194.04	07954	MOB - MAIN CAMPUS	0	0	0	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	1,466,283	0	0	1,466,283
194.07	07957	KDH - MC ORTHOPEDICS	0	0	0	0	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	0	0	0	194.08
194.09	07959	KDH - MC ENT	0	0	0	0	194.09

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/28/2019 12:26 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP		
		0	1.00	1.01		
194.10 07960 KDH - MC UROLOGY	0	0	0	0	0	194.10
194.11 07961 KDH - MC OB/GYN	0	0	0	0	0	194.11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	12,576,810	7,887	0	12,584,697	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0069

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

Worksheet B
Part II
Date/Time Prepared:
5/28/2019 12:26 pm

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	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,478,789			5.00
7.00	00700	OPERATION OF PLANT	0	69,632	1,466,893		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,448	9,676	80,898	8.00
9.00	00900	HOUSEKEEPING	0	21,866	16,962	0	9.00
10.00	01000	DIETARY	0	16,012	31,948	0	10.00
11.00	01100	CAFETERIA	0	2,097	12,920	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,331	10,347	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,165	15,718	0	14.00
15.00	01500	PHARMACY	0	24,702	11,682	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,422	1,482	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00	02300	RADIOLOGY SCHOOL	0	2,164	3,356	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	93,082	202,066	25,134	30.00
31.00	03100	INTENSIVE CARE UNIT	0	21,424	8,499	0	31.00
43.00	04300	NURSERY	0	10,836	9,925	1,775	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	58,424	93,596	16,084	50.00
51.00	05100	RECOVERY ROOM	0	5,490	6,981	2,090	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,168	0	1,658	52.00
53.00	05300	ANESTHESIOLOGY	0	2,732	660	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	45,785	55,037	5,024	54.00
54.01	03630	ULTRA SOUND	0	2,751	0	560	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	4,614	2,452	336	54.02
55.00	03480	ONCOLOGY	0	33,659	62,175	2,391	55.00
57.00	05700	CT SCAN	0	4,803	4,544	2,522	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,077	5,483	560	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	55,071	31,674	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,375	1,416	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	12,742	6,077	0	65.00
66.00	06600	PHYSICAL THERAPY	0	31,750	62,957	3,520	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,580	7,209	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,154	1,706	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03610	SLEEP LAB	0	4,278	4,259	296	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	45,222	0	0	71.00
71.01	07101	IV SOLUTIONS	0	1,955	0	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	90,358	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	131,385	0	0	73.00
76.00	03140	CARDIOLOGY	0	14,774	30,699	2,812	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,790	3,569	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	2,665	4,417	1	90.00
91.00	09100	EMERGENCY	0	46,487	70,461	13,308	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	33,273	24,023	1,569	95.00
101.00	10100	HOME HEALTH AGENCY	0	18,455	13,951	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	2,871	3,777	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	973,869	831,704	79,640	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	393	3,818	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07951	MOB	0	74,925	267,218	157	194.01
194.02	07952	PHYSICIAN CLINICS	0	135,685	140,089	392	194.02
194.03	07953	PHYS PRAC BUS OFC	0	26,375	5,021	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0	7,428	0	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	86,268	219,043	9	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	80,109	0	115	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	29,915	0	255	194.08
194.09	07959	KDH - MC ENT	0	11,437	0	0	194.09
194.10	07960	KDH - MC UROLOGY	0	9,468	0	0	194.10
194.11	07961	KDH - MC OB/GYN	0	42,917	0	330	194.11
200.00		Cross Foot Adjustments					200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0069

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

Worksheet B
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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	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	1,478,789	1,466,893	80,898	152,369	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part II Date/Time Prepared: 5/28/2019 12:26 pm	
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	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO						1.01
2.00	00200	NEW 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	261,823					10.00
11.00	01100	CAFETERIA	0	95,407				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	88,938			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	684	0	126,213		14.00
15.00	01500	PHARMACY	0	2,538	0	342	120,336	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,029	0	75	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	RADIOLOGY SCHOOL	0	545	0	8	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	240,855	17,887	36,011	1,720	0	30.00
31.00	03100	INTENSIVE CARE UNIT	20,968	3,745	7,540	0	0	31.00
43.00	04300	NURSERY	0	1,890	3,806	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	9,498	19,121	2,851	0	50.00
51.00	05100	RECOVERY ROOM	0	1,039	2,091	47	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,766	3,556	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	773	0	233	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,929	0	581	0	54.00
54.01	03630	ULTRA SOUND	0	399	0	272	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	295	0	43	0	54.02
55.00	03480	ONCOLOGY	0	3,244	0	584	0	55.00
57.00	05700	CT SCAN	0	775	0	1,469	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	485	0	218	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	9,319	0	443	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	2,751	0	57	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,773	0	134	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	600	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	505	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03610	SLEEP LAB	0	451	0	2	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	36,719	0	71.00
71.01	07101	IV SOLUTIONS	0	0	0	1,588	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	73,369	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	486	120,336	73.00
76.00	03140	CARDIOLOGY	0	2,179	0	61	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	376	0	3	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	387	0	5	0	90.00
91.00	09100	EMERGENCY	0	8,351	16,813	508	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	9,194	0	84	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	321	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	261,823	95,407	88,938	122,223	120,336	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	256	0	194.01
194.02	07952	PHYSICIAN CLINICS	0	0	0	896	0	194.02
194.03	07953	PHYS PRAC BUS OFC	0	0	0	111	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0	0	0	91	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	0	0	250	0	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	0	0	1,268	0	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	0	0	531	0	194.08
194.09	07959	KDH - MC ENT	0	0	0	74	0	194.09
194.10	07960	KDH - MC UROLOGY	0	0	0	253	0	194.10
194.11	07961	KDH - MC OB/GYN	0	0	0	260	0	194.11
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0069			Period: From 01/01/2018 To 12/31/2018		Worksheet B Part II Date/Time Prepared: 5/28/2019 12:26 pm	
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
		10.00	11.00	13.00	14.00	15.00		
201.00	Negative Cost Centers	0	6,100	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	261,823	101,507	88,938	126,213	120,336	202.00	

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part II Date/Time Prepared: 5/28/2019 12:26 pm	
Cost Center Description			MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	RADIOLOGY SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	19.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO						1.01
2.00	00200	NEW 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	29,931					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
23.00	02300	RADIOLOGY SCHOOL	0		28,842			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	931			2,044,502	0	30.00
31.00	03100	INTENSIVE CARE UNIT	311			123,560	0	31.00
43.00	04300	NURSERY	161			95,526	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,047			837,060	0	50.00
51.00	05100	RECOVERY ROOM	621			65,087	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	147			19,421	0	52.00
53.00	05300	ANESTHESIOLOGY	642			9,458	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	678			487,415	0	54.00
54.01	03630	ULTRA SOUND	188			5,461	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	552			25,064	0	54.02
55.00	03480	ONCOLOGY	632			528,364	0	55.00
57.00	05700	CT SCAN	1,569			46,624	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	400			49,371	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0			0	0	59.00
60.00	06000	LABORATORY	3,077			316,744	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	184			15,457	0	62.00
65.00	06500	RESPIRATORY THERAPY	733			63,039	0	65.00
66.00	06600	PHYSICAL THERAPY	919			528,590	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	111			60,758	0	67.00
68.00	06800	SPEECH PATHOLOGY	89			16,873	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0			0	0	69.00
69.01	03610	SLEEP LAB	171			40,010	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,350			83,291	0	71.00
71.01	07101	IV SOLUTIONS	227			3,770	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,147			165,874	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,839			259,046	0	73.00
76.00	03140	CARDIOLOGY	1,059			257,712	0	76.00
76.97	07697	CARDIAC REHABILITATION	60			29,689	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	14			37,662	0	90.00
91.00	09100	EMERGENCY	2,537			641,145	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	535			229,491	0	95.00
101.00	10100	HOME HEALTH AGENCY	0			38,934	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0			8,328	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,931	0	0	7,133,326	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0			29,767	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0			0	0	194.00
194.01	07951	MOB	0			2,131,313	0	194.01
194.02	07952	PHYSICIAN CLINICS	0			1,214,822	0	194.02
194.03	07953	PHYS PRAC BUS OFC	0			65,117	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0			26,625	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0			0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0			1,771,853	0	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0			81,492	0	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0			30,701	0	194.08
194.09	07959	KDH - MC ENT	0			11,511	0	194.09
194.10	07960	KDH - MC UROLOGY	0			9,721	0	194.10

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part II Date/Time Prepared: 5/28/2019 12:26 pm	
Cost Center Description			MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	RADIOLOGY SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	19.00	23.00	24.00	25.00	
194.11	07961	KDH - MC OB/GYN	0			43,507		0
200.00		Cross Foot Adjustments		0	28,842	28,842		0
201.00		Negative Cost Centers	0	0	0	6,100		0
202.00		TOTAL (sum lines 118 through 201)	29,931	0	28,842	12,584,697		0

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/28/2019 12:26 pm
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	1.01
2.00	00200	NEW 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
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
23.00	02300	RADIOLOGY SCHOOL	23.00
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
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRA SOUND	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	54.02
55.00	03480	ONCOLOGY	55.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00
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
69.01	03610	SLEEP LAB	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
71.01	07101	IV SOLUTIONS	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03140	CARDIOLOGY	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
194.00	07950	OTHER NON-REIMBURSABLE	194.00
194.01	07951	MOB	194.01
194.02	07952	PHYSICIAN CLINICS	194.02
194.03	07953	PHYS PRAC BUS OFC	194.03
194.04	07954	MOB - MAIN CAMPUS	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	194.06
194.07	07957	KDH - MC ORTHOPEDICS	194.07
194.08	07958	KDH - MC GENERAL SURGERY	194.08
194.09	07959	KDH - MC ENT	194.09
194.10	07960	KDH - MC UROLOGY	194.10
194.11	07961	KDH - MC OB/GYN	194.11
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
	1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	370,078				1.00
1.01 00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	3,492			1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP			373,570		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	51,570,637	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	43,514	0	43,514	6,674,881	5.00
7.00 00700	OPERATION OF PLANT	41,115	0	41,115	573,359	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,906	0	1,906	47,228	8.00
9.00 00900	HOUSEKEEPING	3,341	0	3,341	708,780	9.00
10.00 01000	DIETARY	6,293	0	6,293	447,778	10.00
11.00 01100	CAFETERIA	2,545	0	2,545	251,304	11.00
13.00 01300	NURSING ADMINISTRATION	2,038	0	2,038	428,327	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	3,096	0	3,096	79,264	14.00
15.00 01500	PHARMACY	2,301	0	2,301	720,881	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	292	0	292	527,472	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	RADIOLOGY SCHOOL	661	0	661	123,446	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	39,802	0	39,802	3,836,529	30.00
31.00 03100	INTENSIVE CARE UNIT	1,674	0	1,674	1,058,638	31.00
43.00 04300	NURSERY	1,955	0	1,955	498,311	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	18,436	0	18,436	1,939,965	50.00
51.00 05100	RECOVERY ROOM	1,375	0	1,375	288,550	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	465,553	52.00
53.00 05300	ANESTHESIOLOGY	130	0	130	1,174,629	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	10,841	0	10,841	2,752,211	54.00
54.01 03630	ULTRA SOUND	0	0	0	121,855	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	483	0	483	66,188	54.02
55.00 03480	ONCOLOGY	12,247	0	12,247	837,829	55.00
57.00 05700	CT SCAN	895	0	895	170,468	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,080	0	1,080	131,504	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	6,239	0	6,239	1,440,461	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	279	0	279	0	62.00
65.00 06500	RESPIRATORY THERAPY	1,197	0	1,197	602,708	65.00
66.00 06600	PHYSICAL THERAPY	12,401	0	12,401	1,292,144	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,420	0	1,420	196,223	67.00
68.00 06800	SPEECH PATHOLOGY	336	0	336	153,470	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01 03610	SLEEP LAB	839	0	839	139,011	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
71.01 07101	IV SOLUTIONS	0	0	0	0	71.01
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03140	CARDIOLOGY	6,047	0	6,047	436,700	76.00
76.97 07697	CARDIAC REHABILITATION	703	0	703	69,977	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	870	0	870	111,314	90.00
91.00 09100	EMERGENCY	13,879	0	13,879	1,707,980	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	4,732	0	4,732	1,468,829	95.00
101.00 10100	HOME HEALTH AGENCY	0	2,748	2,748	877,564	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	744	744	92,580	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	244,962	3,492	248,454	32,513,911	-15,248,599
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	752	0	752	0	190.00
194.00 07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01 07951	MOB	52,635	0	52,635	2,172,011	194.01
194.02 07952	PHYSICIAN CLINICS	27,594	0	27,594	5,112,138	194.02
194.03 07953	PHYS PRAC BUS OFC	989	0	989	670,989	194.03
194.04 07954	MOB - MAIN CAMPUS	0	0	0	389,029	194.04
194.05 07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	194.05
194.06 07956	KDH - MC FAMILY PRACTICE	43,146	0	43,146	3,074,766	194.06
194.07 07957	KDH - MC ORTHOPEDICS	0	0	0	3,830,988	194.07
194.08 07958	KDH - MC GENERAL SURGERY	0	0	0	1,370,313	194.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
	1.00	1.01	2.00			
194.09 07959 KDH - MC ENT	0	0	0	574,789	0	194.09
194.10 07960 KDH - MC UROLOGY	0	0	0	96,052	0	194.10
194.11 07961 KDH - MC OB/GYN	0	0	0	1,765,651	0	194.11
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)	12,576,810	7,887	0	12,900,888		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	33.984214	2.258591	0.000000	0.250160		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1
Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	96,108,359				5.00
7.00	00700	OPERATION OF PLANT	4,525,354	288,941			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	419,024	1,906	414,381		8.00
9.00	00900	HOUSEKEEPING	1,421,047	3,341	0	48,989	9.00
10.00	01000	DIETARY	1,040,640	6,293	0	48,437	10.00
11.00	01100	CAFETERIA	136,305	2,545	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	606,447	2,038	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	205,668	3,096	0	460	14.00
15.00	01500	PHARMACY	1,605,364	2,301	0	924	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,002,255	292	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00	02300	RADIOLOGY SCHOOL	140,660	661	0	98	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,049,417	39,802	128,740	23,849	44,558
31.00	03100	INTENSIVE CARE UNIT	1,392,374	1,674	0	1,345	3,879
43.00	04300	NURSERY	704,206	1,955	9,092	223	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,796,989	18,436	82,389	2,542	0
51.00	05100	RECOVERY ROOM	356,786	1,375	10,703	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	595,842	0	8,495	1,005	0
53.00	05300	ANESTHESIOLOGY	177,569	130	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,975,572	10,841	25,734	1,594	0
54.01	03630	ULTRA SOUND	178,759	0	2,870	415	0
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	299,895	483	1,721	115	0
55.00	03480	ONCOLOGY	2,187,516	12,247	12,246	3,046	0
57.00	05700	CT SCAN	312,115	895	12,916	169	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	329,965	1,080	2,868	143	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	3,579,076	6,239	0	1,650	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	284,303	279	0	0	0
65.00	06500	RESPIRATORY THERAPY	828,095	1,197	0	0	0
66.00	06600	PHYSICAL THERAPY	2,063,455	12,401	18,028	675	0
67.00	06700	OCCUPATIONAL THERAPY	297,662	1,420	0	0	0
68.00	06800	SPEECH PATHOLOGY	204,978	336	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
69.01	03610	SLEEP LAB	278,058	839	1,517	656	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,938,942	0	0	0	0
71.01	07101	IV SOLUTIONS	127,073	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,872,363	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	8,538,718	0	0	0	0
76.00	03140	CARDIOLOGY	960,142	6,047	14,406	201	0
76.97	07697	CARDIAC REHABILITATION	116,338	703	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	173,198	870	3	195	0
91.00	09100	EMERGENCY	3,021,158	13,879	68,168	3,541	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,162,399	4,732	8,037	0	0
101.00	10100	HOME HEALTH AGENCY	1,199,399	2,748	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	186,608	744	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,291,734	163,825	407,933	42,846	48,437
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	25,556	752	0	0	0
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0
194.01	07951	MOB	4,869,370	52,635	805	0	0
194.02	07952	PHYSICIAN CLINICS	8,819,972	27,594	2,010	0	0
194.03	07953	PHYS PRAC BUS OFC	1,714,124	989	0	0	0
194.04	07954	MOB - MAIN CAMPUS	482,762	0	0	6,143	0
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	0
194.06	07956	KDH - MC FAMILY PRACTICE	5,606,538	43,146	47	0	0
194.07	07957	KDH - MC ORTHOPEDICS	5,206,275	0	588	0	0
194.08	07958	KDH - MC GENERAL SURGERY	1,944,179	0	1,308	0	0
194.09	07959	KDH - MC ENT	743,321	0	0	0	0
194.10	07960	KDH - MC UROLOGY	615,355	0	0	0	0
194.11	07961	KDH - MC OB/GYN	2,789,173	0	1,690	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	15,248,599	5,243,347	520,094	1,707,138	1,319,946	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.158660	18.146774	1.255111	34.847374	27.250779	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,478,789	1,466,893	80,898	152,369	261,823	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.015387	5.076791	0.195226	3.110270	5.405434	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: 15-0069

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

Worksheet B-1

Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING 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	770,697					11.00
13.00	01300		356,859				13.00
14.00	01400	5,523		10,101,853			14.00
15.00	01500	20,501		27,387	100		15.00
16.00	01600	24,466		6,038		290,783,017	16.00
19.00	01900						19.00
23.00	02300	4,403		663			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	144,491	144,491	137,674		9,042,416	30.00
31.00	03100	30,254	30,254	10		3,017,060	31.00
43.00	04300	15,271	15,271			1,560,600	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	76,724	76,724	228,189		29,578,818	50.00
51.00	05100	8,390	8,390	3,747		6,026,538	51.00
52.00	05200	14,268	14,268			1,431,145	52.00
53.00	05300	6,245		18,664		6,234,673	53.00
54.00	05400	55,973		46,537		6,581,343	54.00
54.01	03630	3,226		21,764		1,823,839	54.01
54.02	03450	2,382		3,480		5,356,266	54.02
55.00	03480	26,202		46,778		6,131,987	55.00
57.00	05700	6,257		117,558		15,235,148	57.00
58.00	05800	3,918		17,443		3,879,226	58.00
59.00	05900						59.00
60.00	06000	75,282		35,460		29,875,537	60.00
62.00	06200					1,788,938	62.00
65.00	06500	22,224		4,579		7,117,821	65.00
66.00	06600	46,633		10,713		8,921,996	66.00
67.00	06700	4,848				1,079,300	67.00
68.00	06800	4,082				861,176	68.00
69.00	06900						69.00
69.01	03610	3,644		153		1,664,577	69.01
71.00	07100			2,938,948		13,104,295	71.00
71.01	07101			127,073		2,200,917	71.01
72.00	07200			5,872,363		20,848,737	72.00
73.00	07300			38,921	100	66,591,803	73.00
76.00	03140	17,600		4,848		10,282,430	76.00
76.97	07697	3,034		225		582,732	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	3,128		372		135,136	90.00
91.00	09100	67,461	67,461	40,626		24,635,339	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	74,267		6,686		5,193,224	95.00
101.00	10100			25,670			101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600						116.00
118.00		770,697	356,859	9,782,569	100	290,783,017	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000						190.00
194.00	07950						194.00
194.01	07951			20,459			194.01
194.02	07952			71,738			194.02
194.03	07953			8,873			194.03
194.04	07954			7,277			194.04
194.05	07955						194.05
194.06	07956			19,989			194.06
194.07	07957			101,450			194.07
194.08	07958			42,501			194.08
194.09	07959			5,905			194.09
194.10	07960			20,264			194.10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
194.11	07961 KDH - MC OB/GYN	0	0	20,828	0	0	194.11
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)	204,115	739,649	311,974	1,940,302	1,173,238	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.264845	2.072665	0.030883	19,403.020000	0.004035	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	101,507	88,938	126,213	120,336	29,931	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.123793	0.249224	0.012494	1,203.360000	0.000103	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: 15-0069

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	RADIOLOGY SCHOOL (ASSIGNED TIME)	
		19.00	23.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO		1.01
2.00	00200	NEW 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
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
23.00	02300	RADIOLOGY SCHOOL		23.00
			1,000	
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
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	03630	ULTRA SOUND	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	54.02
55.00	03480	ONCOLOGY	0	55.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
69.01	03610	SLEEP LAB	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
71.01	07101	IV SOLUTIONS	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03140	CARDIOLOGY	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
			1,000	
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	194.00
194.01	07951	MOB	0	194.01
194.02	07952	PHYSICIAN CLINICS	0	194.02
194.03	07953	PHYS PRAC BUS OFC	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	194.08
194.09	07959	KDH - MC ENT	0	194.09
194.10	07960	KDH - MC UROLOGY	0	194.10
194.11	07961	KDH - MC OB/GYN	0	194.11

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	RADIOLOGY SCHOOL (ASSIGNED TIME)	
		19.00	23.00	
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	179,573	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	179.573000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	28,842	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	28.842000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0069

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2019 12:26 pm

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		10,316,882	0	10,316,882	30.00	
31.00	03100 INTENSIVE CARE UNIT		1,879,135	0	1,879,135	31.00	
43.00	04300 NURSERY		912,587	0	912,587	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		5,231,703	0	5,231,703	50.00	
51.00	05100 RECOVERY ROOM		495,824	0	495,824	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		775,189	0	775,189	52.00	
53.00	05300 ANESTHESIOLOGY		235,488	17,024	252,512	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,954,641	0	3,954,641	54.00	
54.01	03630 ULTRA SOUND		234,070	0	234,070	54.01	
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC		384,759	0	384,759	54.02	
55.00	03480 ONCOLOGY		2,911,473	0	2,911,473	55.00	
57.00	05700 CT SCAN		466,738	0	466,738	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		427,729	0	427,729	58.00	
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00	
60.00	06000 LABORATORY		4,459,229	0	4,459,229	60.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		341,692	0	341,692	62.00	
65.00	06500 RESPIRATORY THERAPY	0	1,015,950	0	1,015,950	65.00	
66.00	06600 PHYSICAL THERAPY	0	2,710,712	0	2,710,712	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	376,296	0	376,296	67.00	
68.00	06800 SPEECH PATHOLOGY	0	248,153	0	248,153	68.00	
69.00	06900 ELECTROCARDIOLOGY		0	0	0	69.00	
69.01	03610 SLEEP LAB		369,851	0	369,851	69.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		3,548,875	0	3,548,875	71.00	
71.01	07101 IV SOLUTIONS		160,039	0	160,039	71.01	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		7,069,553	0	7,069,553	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		12,103,598	0	12,103,598	73.00	
76.00	03140 RADIOLOGY		1,293,598	0	1,293,598	76.00	
76.97	07697 CARDIAC REHABILITATION		150,715	0	150,715	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		224,649	0	224,649	90.00	
91.00	09100 EMERGENCY		4,219,657	295,420	4,515,077	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2,013,972	0	2,013,972	92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES		2,642,273	209	2,642,482	95.00	
101.00	10100 HOME HEALTH AGENCY		1,440,356	0	1,440,356	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE					113.00	
116.00	11600 HOSPICE		229,716		229,716	116.00	
200.00	Subtotal (see instructions)	0	72,845,102	312,653	73,157,755	200.00	
201.00	Less Observation Beds		2,013,972		2,013,972	201.00	
202.00	Total (see instructions)	0	70,831,130	312,653	71,143,783	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0069

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2019 12:26 pm

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,042,416		9,042,416		30.00
31.00	03100	INTENSIVE CARE UNIT	3,017,060		3,017,060		31.00
43.00	04300	NURSERY	1,560,600		1,560,600		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,988,226	22,590,592	29,578,818	0.176873	50.00
51.00	05100	RECOVERY ROOM	1,616,978	4,409,560	6,026,538	0.082273	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,418,217	12,928	1,431,145	0.0541657	52.00
53.00	05300	ANESTHESIOLOGY	2,088,900	4,145,774	6,234,674	0.037771	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,240,642	5,340,702	6,581,344	0.0600887	54.00
54.01	03630	ULTRA SOUND	243,877	1,579,962	1,823,839	0.128339	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	375,281	4,980,985	5,356,266	0.071833	54.02
55.00	03480	ONCOLOGY	90,641	6,041,346	6,131,987	0.0474801	55.00
57.00	05700	CT SCAN	2,374,560	12,860,588	15,235,148	0.030636	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	257,914	3,621,313	3,879,227	0.110261	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	5,098,101	24,777,435	29,875,536	0.149260	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,016,373	772,565	1,788,938	0.191003	62.00
65.00	06500	RESPIRATORY THERAPY	5,212,358	1,905,464	7,117,822	0.142733	65.00
66.00	06600	PHYSICAL THERAPY	944,757	7,977,239	8,921,996	0.0303823	66.00
67.00	06700	OCCUPATIONAL THERAPY	338,411	740,889	1,079,300	0.0348648	67.00
68.00	06800	SPEECH PATHOLOGY	105,545	755,631	861,176	0.0288156	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
69.01	03610	SLEEP LAB	4,927	1,659,650	1,664,577	0.022189	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,458,690	7,645,605	13,104,295	0.0270818	71.00
71.01	07101	IV SOLUTIONS	1,257,477	943,440	2,200,917	0.072715	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,307,439	10,541,298	20,848,737	0.0339088	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,647,702	45,944,101	66,591,803	0.0181758	73.00
76.00	03140	CARDIOLOGY	1,983,803	8,298,626	10,282,429	0.0125807	76.00
76.97	07697	CARDIAC REHABILITATION	716	582,016	582,732	0.0258635	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,249	131,887	135,136	1.662392	90.00
91.00	09100	EMERGENCY	4,116,076	20,519,263	24,635,339	0.171285	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	462,224	2,624,136	3,086,360	0.0652540	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	5,193,224	5,193,224	0.0508792	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,735,030	1,735,030		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	318,742	318,742		116.00
200.00		Subtotal (see instructions)	87,273,160	208,649,991	295,923,151		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	87,273,160	208,649,991	295,923,151		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 12:26 pm
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	0.176873		50.00
51.00	05100 RECOVERY ROOM	0.082273		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.541657		52.00
53.00	05300 ANESTHESIOLOGY	0.040501		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.600887		54.00
54.01	03630 ULTRA SOUND	0.128339		54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.071833		54.02
55.00	03480 ONCOLOGY	0.474801		55.00
57.00	05700 CT SCAN	0.030636		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.110261		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.149260		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.191003		62.00
65.00	06500 RESPIRATORY THERAPY	0.142733		65.00
66.00	06600 PHYSICAL THERAPY	0.303823		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.348648		67.00
68.00	06800 SPEECH PATHOLOGY	0.288156		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	03610 SLEEP LAB	0.222189		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270818		71.00
71.01	07101 IV SOLUTIONS	0.072715		71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.339088		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.181758		73.00
76.00	03140 RADIOLOGY	0.125807		76.00
76.97	07697 CARDIAC REHABILITATION	0.258635		76.97
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	1.662392		90.00
91.00	09100 EMERGENCY	0.183276		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.652540		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.508833		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0069

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2019 12:26 pm

		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	10,316,882		10,316,882	0	10,316,882 30.00
31.00	03100 INTENSIVE CARE UNIT	1,879,135		1,879,135	0	1,879,135 31.00
43.00	04300 NURSERY	912,587		912,587	0	912,587 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5,231,703		5,231,703	0	5,231,703 50.00
51.00	05100 RECOVERY ROOM	495,824		495,824	0	495,824 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	775,189		775,189	0	775,189 52.00
53.00	05300 ANESTHESIOLOGY	235,488		235,488	17,024	252,512 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,954,641		3,954,641	0	3,954,641 54.00
54.01	03630 ULTRA SOUND	234,070		234,070	0	234,070 54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	384,759		384,759	0	384,759 54.02
55.00	03480 ONCOLOGY	2,911,473		2,911,473	0	2,911,473 55.00
57.00	05700 CT SCAN	466,738		466,738	0	466,738 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	427,729		427,729	0	427,729 58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	06000 LABORATORY	4,459,229		4,459,229	0	4,459,229 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	341,692		341,692	0	341,692 62.00
65.00	06500 RESPIRATORY THERAPY	1,015,950	0	1,015,950	0	1,015,950 65.00
66.00	06600 PHYSICAL THERAPY	2,710,712	0	2,710,712	0	2,710,712 66.00
67.00	06700 OCCUPATIONAL THERAPY	376,296	0	376,296	0	376,296 67.00
68.00	06800 SPEECH PATHOLOGY	248,153	0	248,153	0	248,153 68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0 69.00
69.01	03610 SLEEP LAB	369,851		369,851	0	369,851 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,548,875		3,548,875	0	3,548,875 71.00
71.01	07101 IV SOLUTIONS	160,039		160,039	0	160,039 71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7,069,553		7,069,553	0	7,069,553 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,103,598		12,103,598	0	12,103,598 73.00
76.00	03140 RADIOLOGY	1,293,598		1,293,598	0	1,293,598 76.00
76.97	07697 CARDIAC REHABILITATION	150,715		150,715	0	150,715 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	224,649		224,649	0	224,649 90.00
91.00	09100 EMERGENCY	4,219,657		4,219,657	295,420	4,515,077 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,013,972		2,013,972		2,013,972 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	2,642,273		2,642,273	209	2,642,482 95.00
101.00	10100 HOME HEALTH AGENCY	1,440,356		1,440,356		1,440,356 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
116.00	11600 HOSPICE	229,716		229,716		229,716 116.00
200.00	Subtotal (see instructions)	72,845,102	0	72,845,102	312,653	73,157,755 200.00
201.00	Less Observation Beds	2,013,972		2,013,972		2,013,972 201.00
202.00	Total (see instructions)	70,831,130	0	70,831,130	312,653	71,143,783 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0069

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

Worksheet C
Part I
Date/Time Prepared:
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		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,042,416		9,042,416		30.00
31.00	03100	INTENSIVE CARE UNIT	3,017,060		3,017,060		31.00
43.00	04300	NURSERY	1,560,600		1,560,600		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,988,226	22,590,592	29,578,818	0.176873	50.00
51.00	05100	RECOVERY ROOM	1,616,978	4,409,560	6,026,538	0.082273	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,418,217	12,928	1,431,145	0.0541657	52.00
53.00	05300	ANESTHESIOLOGY	2,088,900	4,145,774	6,234,674	0.037771	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,240,642	5,340,702	6,581,344	0.0600887	54.00
54.01	03630	ULTRA SOUND	243,877	1,579,962	1,823,839	0.128339	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	375,281	4,980,985	5,356,266	0.071833	54.02
55.00	03480	ONCOLOGY	90,641	6,041,346	6,131,987	0.0474801	55.00
57.00	05700	CT SCAN	2,374,560	12,860,588	15,235,148	0.030636	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	257,914	3,621,313	3,879,227	0.110261	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	5,098,101	24,777,435	29,875,536	0.149260	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,016,373	772,565	1,788,938	0.191003	62.00
65.00	06500	RESPIRATORY THERAPY	5,212,358	1,905,464	7,117,822	0.142733	65.00
66.00	06600	PHYSICAL THERAPY	944,757	7,977,239	8,921,996	0.0303823	66.00
67.00	06700	OCCUPATIONAL THERAPY	338,411	740,889	1,079,300	0.0348648	67.00
68.00	06800	SPEECH PATHOLOGY	105,545	755,631	861,176	0.0288156	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
69.01	03610	SLEEP LAB	4,927	1,659,650	1,664,577	0.022189	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,458,690	7,645,605	13,104,295	0.0270818	71.00
71.01	07101	IV SOLUTIONS	1,257,477	943,440	2,200,917	0.072715	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,307,439	10,541,298	20,848,737	0.0339088	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,647,702	45,944,101	66,591,803	0.0181758	73.00
76.00	03140	CARDIOLOGY	1,983,803	8,298,626	10,282,429	0.0125807	76.00
76.97	07697	CARDIAC REHABILITATION	716	582,016	582,732	0.0258635	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,249	131,887	135,136	1.662392	90.00
91.00	09100	EMERGENCY	4,116,076	20,519,263	24,635,339	0.171285	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	462,224	2,624,136	3,086,360	0.0652540	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	5,193,224	5,193,224	0.0508792	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,735,030	1,735,030		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	318,742	318,742		116.00
200.00		Subtotal (see instructions)	87,273,160	208,649,991	295,923,151		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	87,273,160	208,649,991	295,923,151		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 12:26 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
	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	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630 ULTRA SOUND	0.000000		54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000		54.02
55.00	03480 ONCOLOGY	0.000000		55.00
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
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
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
69.01	03610 SLEEP LAB	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
71.01	07101 IV SOLUTIONS	0.000000		71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03140 RADIOLOGY	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0069		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part I Date/Time Prepared: 5/28/2019 12:26 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,044,502	0	2,044,502	11,736	174.21	30.00
31.00	INTENSIVE CARE UNIT	123,560		123,560	1,432	86.28	31.00
43.00	NURSERY	95,526		95,526	1,228	77.79	43.00
200.00	Total (Lines 30 through 199)	2,263,588		2,263,588	14,396		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	5,149	897,007				
31.00	INTENSIVE CARE UNIT	701	60,482				
43.00	NURSERY	0	0				
200.00	Total (Lines 30 through 199)	5,850	957,489				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0069

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

Worksheet D
Part II
Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	837,060	29,578,818	0.028299	2,537,996	71,823	50.00
51.00	05100	RECOVERY ROOM	65,087	6,026,538	0.010800	704,168	7,605	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,421	1,431,145	0.013570	18,384	249	52.00
53.00	05300	ANESTHESIOLOGY	9,458	6,234,674	0.001517	598,368	908	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	487,415	6,581,344	0.074060	808,105	59,848	54.00
54.01	03630	ULTRA SOUND	5,461	1,823,839	0.002994	118,434	355	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	25,064	5,356,266	0.004679	233,318	1,092	54.02
55.00	03480	ONCOLOGY	528,364	6,131,987	0.086165	69,066	5,951	55.00
57.00	05700	CT SCAN	46,624	15,235,148	0.003060	1,497,668	4,583	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	49,371	3,879,227	0.012727	169,135	2,153	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	316,744	29,875,536	0.010602	3,202,428	33,952	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	15,457	1,788,938	0.008640	500,017	4,320	62.00
65.00	06500	RESPIRATORY THERAPY	63,039	7,117,822	0.008857	3,304,542	29,268	65.00
66.00	06600	PHYSICAL THERAPY	528,590	8,921,996	0.059246	545,891	32,342	66.00
67.00	06700	OCCUPATIONAL THERAPY	60,758	1,079,300	0.056294	204,300	11,501	67.00
68.00	06800	SPEECH PATHOLOGY	16,873	861,176	0.019593	73,800	1,446	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03610	SLEEP LAB	40,010	1,664,577	0.024036	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,291	13,104,295	0.006356	2,291,459	14,565	71.00
71.01	07101	IV SOLUTIONS	3,770	2,200,917	0.001713	664,934	1,139	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	165,874	20,848,737	0.007956	3,939,504	31,343	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	259,046	66,591,803	0.003890	10,573,075	41,129	73.00
76.00	03140	CARDIOLOGY	257,712	10,282,429	0.025063	1,262,475	31,641	76.00
76.97	07697	CARDIAC REHABILITATION	29,689	582,732	0.050948	490	25	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	37,662	135,136	0.278697	0	0	90.00
91.00	09100	EMERGENCY	641,145	24,635,339	0.026025	2,469,772	64,276	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	399,111	3,086,360	0.129314	337,406	43,631	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	4,992,096	275,056,079		36,124,735	495,145	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Prepared: 5/28/2019 12:26 pm
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Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
		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 col. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	
		4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	11,736	0.00	5,149	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,432	0.00	701	31.00
43.00	04300	NURSERY	0	1,228	0.00	0	43.00
200.00		Total (lines 30 through 199)	0	14,396		5,850	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: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 12:26 pm
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Cost Center Description	Title XVIII				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	179,573	0	54.00
54.01 03630 ULTRA SOUND	0	0	0	0	0	0	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	0	54.02
55.00 03480 ONCOLOGY	0	0	0	0	0	0	55.00
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
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
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
69.01 03610 SLEEP LAB	0	0	0	0	0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
71.01 07101 IV SOLUTIONS	0	0	0	0	0	0	71.01
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
76.00 03140 RADIOLOGY	0	0	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	0	95.00
200.00 Total (lines 50 through 199)	0	0	0	0	179,573	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 12:26 pm
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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	29,578,818	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,026,538	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,431,145	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,234,674	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	179,573	179,573	6,581,344	0.027285	54.00
54.01	03630	ULTRA SOUND	0	0	0	1,823,839	0.000000	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	5,356,266	0.000000	54.02
55.00	03480	ONCOLOGY	0	0	0	6,131,987	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	15,235,148	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,879,227	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	29,875,536	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1,788,938	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,117,822	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,921,996	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,079,300	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	861,176	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	03610	SLEEP LAB	0	0	0	1,664,577	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	13,104,295	0.000000	71.00
71.01	07101	IV SOLUTIONS	0	0	0	2,200,917	0.000000	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20,848,737	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	66,591,803	0.000000	73.00
76.00	03140	CARDIOLOGY	0	0	0	10,282,429	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	582,732	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	135,136	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,635,339	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,086,360	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	179,573	179,573	275,056,079		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 12:26 pm
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Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	2,537,996	0	8,256,313	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	704,168	0	1,453,894	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	18,384	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	598,368	0	1,171,210	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.027285	808,105	22,049	1,567,632	42,773	54.00
54.01	03630 ULTRA SOUND	0.000000	118,434	0	335,252	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	233,318	0	2,227,735	0	54.02
55.00	03480 ONCOLOGY	0.000000	69,066	0	3,113,516	0	55.00
57.00	05700 CT SCAN	0.000000	1,497,668	0	4,289,599	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	169,135	0	1,248,215	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	3,202,428	0	2,899,049	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	500,017	0	208,255	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.000000	3,304,542	0	482,428	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	545,891	0	122,327	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	204,300	0	55,598	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	73,800	0	1,691	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03610 SLEEP LAB	0.000000	0	0	608,137	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,291,459	0	2,168,089	0	71.00
71.01	07101 IV SOLUTIONS	0.000000	664,934	0	304,102	0	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,939,504	0	5,408,410	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	10,573,075	0	20,302,293	0	73.00
76.00	03140 RADIOLOGY	0.000000	1,262,475	0	3,622,770	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	490	0	277,438	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	18,000	0	90.00
91.00	09100 EMERGENCY	0.000000	2,469,772	0	4,864,090	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	337,406	0	745,888	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		36,124,735	22,049	65,751,931	42,773	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/28/2019 12:26 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.176873	8,256,313	64	0	1,460,319	50.00
51.00	05100 RECOVERY ROOM	0.082273	1,453,894	0	0	119,616	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.541657	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.037771	1,171,210	0	0	44,238	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.600887	1,567,632	0	0	941,970	54.00
54.01	03630 ULTRA SOUND	0.128339	335,252	0	0	43,026	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.071833	2,227,735	0	0	160,025	54.02
55.00	03480 ONCOLOGY	0.474801	3,113,516	156	0	1,478,301	55.00
57.00	05700 CT SCAN	0.030636	4,289,599	0	0	131,416	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.110261	1,248,215	0	0	137,629	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.149260	2,899,049	0	0	432,712	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.191003	208,255	33	0	39,777	62.00
65.00	06500 RESPIRATORY THERAPY	0.142733	482,428	0	0	68,858	65.00
66.00	06600 PHYSICAL THERAPY	0.303823	122,327	481	0	37,166	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.348648	55,598	109	0	19,384	67.00
68.00	06800 SPEECH PATHOLOGY	0.288156	1,691	0	0	487	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03610 SLEEP LAB	0.222189	608,137	0	0	135,121	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270818	2,168,089	0	0	587,158	71.00
71.01	07101 IV SOLUTIONS	0.072715	304,102	0	0	22,113	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.339088	5,408,410	0	0	1,833,927	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.181758	20,302,293	0	41,416	3,690,104	73.00
76.00	03140 RADIOLOGY	0.125807	3,622,770	0	0	455,770	76.00
76.97	07697 CARDIAC REHABILITATION	0.258635	277,438	0	0	71,755	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1.662392	18,000	0	0	29,923	90.00
91.00	09100 EMERGENCY	0.171285	4,864,090	2	145	833,146	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.652540	745,888	0	0	486,722	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.508792		0			95.00
200.00	Subtotal (see instructions)		65,751,931	845	41,561	13,260,663	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		65,751,931	845	41,561	13,260,663	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/28/2019 12:26 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	11	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630 ULTRA SOUND	0	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	54.02
55.00	03480 ONCOLOGY	74	0	55.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	6	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	146	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	38	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
69.01	03610 SLEEP LAB	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
71.01	07101 IV SOLUTIONS	0	0	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7,528	73.00
76.00	03140 RADIOLOGY	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	25	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	275	7,553	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 - line 201)	275	7,553	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/28/2019 12:26 pm
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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	0.176873	0	0	2,850,738	0
51.00	05100 RECOVERY ROOM	0.082273	0	0	1,019,128	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.541657	0	0	1,868	0
53.00	05300 ANESTHESIOLOGY	0.037771	0	0	779,413	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.600887	0	0	1,109,018	0
54.01	03630 ULTRA SOUND	0.128339	0	0	369,486	0
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.071833	0	0	653,914	0
55.00	03480 ONCOLOGY	0.474801	0	0	477,946	0
57.00	05700 CT SCAN	0.030636	0	0	2,214,859	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.110261	0	0	555,857	0
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00	06000 LABORATORY	0.149260	0	0	4,828,776	0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.191003	0	0	39,516	0
65.00	06500 RESPIRATORY THERAPY	0.142733	0	0	408,539	0
66.00	06600 PHYSICAL THERAPY	0.303823	0	0	890,230	0
67.00	06700 OCCUPATIONAL THERAPY	0.348648	0	0	176,794	0
68.00	06800 SPEECH PATHOLOGY	0.288156	0	0	394,635	0
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
69.01	03610 SLEEP LAB	0.222189	0	0	4,561	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270818	0	0	1,163,636	0
71.01	07101 IV SOLUTIONS	0.072715	0	0	189,175	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.339088	0	0	804,654	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.181758	0	0	5,743,578	0
76.00	03140 RADIOLOGY	0.125807	0	0	1,461,126	0
76.97	07697 CARDIAC REHABILITATION	0.258635	0	0	24,258	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	1.662392	0	0	74,755	0
91.00	09100 EMERGENCY	0.171285	0	0	6,433,020	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.652540	0	0	688,723	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.508792	0	0		95.00
200.00	Subtotal (see instructions)		0	0	33,358,203	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0	201.00
202.00	Net Charges (line 200 - line 201)		0	0	33,358,203	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/28/2019 12:26 pm
		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	0	504,219	50.00
51.00	05100	RECOVERY ROOM	0	83,847	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,012	52.00
53.00	05300	ANESTHESIOLOGY	0	29,439	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	666,394	54.00
54.01	03630	ULTRA SOUND	0	47,419	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	46,973	54.02
55.00	03480	ONCOLOGY	0	226,929	55.00
57.00	05700	CT SCAN	0	67,854	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	61,289	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	720,743	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	7,548	62.00
65.00	06500	RESPIRATORY THERAPY	0	58,312	65.00
66.00	06600	PHYSICAL THERAPY	0	270,472	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	61,639	67.00
68.00	06800	SPEECH PATHOLOGY	0	113,716	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03610	SLEEP LAB	0	1,013	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	315,134	71.00
71.01	07101	IV SOLUTIONS	0	13,756	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	272,849	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,043,941	73.00
76.00	03140	CARDIOLOGY	0	183,820	76.00
76.97	07697	CARDIAC REHABILITATION	0	6,274	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	124,272	90.00
91.00	09100	EMERGENCY	0	1,101,880	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	449,419	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	6,480,163	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	6,480,163	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 12:26 pm
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)		11,736	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,736	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		9,445	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)		5,149	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)		10,316,882	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)		10,316,882	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)		10,316,882	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)		879.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,526,383	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,526,383	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/28/2019 12:26 pm	
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		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,879,135	1,432	1,312.25	701	919,887		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)					7,217,685		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					12,663,955		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)					957,489		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					517,194		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,474,683		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					11,189,272		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)					2,291		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					879.08		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,013,972		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/28/2019 12:26 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,044,502	10,316,882	0.198171	2,013,972	399,111	90.00
91.00	Nursing School cost	0	10,316,882	0.000000	2,013,972	0	91.00
92.00	Allied health cost	0	10,316,882	0.000000	2,013,972	0	92.00
93.00	All other Medical Education	0	10,316,882	0.000000	2,013,972	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 12:26 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		11,736	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,736	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		9,445	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)		1,452	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)		1,228	15.00
16.00	Nursery days (title V or XIX only)		299	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)		10,316,882	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)		10,316,882	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)		10,316,882	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)		879.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,276,424	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,276,424	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 12:26 pm		
Cost Center Description			Title XIX		Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	912,587	1,228	743.15	299	222,202	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,879,135	1,432	1,312.25	267	350,371	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)					2,454,989	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,303,986	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)					2,291	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					879.08	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,013,972	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/28/2019 12:26 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,044,502	10,316,882	0.198171	2,013,972	399,111	90.00
91.00	Nursing School cost	0	10,316,882	0.000000	2,013,972	0	91.00
92.00	Allied health cost	0	10,316,882	0.000000	2,013,972	0	92.00
93.00	All other Medical Education	0	10,316,882	0.000000	2,013,972	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/28/2019 12:26 pm
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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		5,201,627		30.00
31.00	03100 INTENSIVE CARE UNIT		1,363,445		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.176873	2,537,996	448,903	50.00
51.00	05100 RECOVERY ROOM	0.082273	704,168	57,934	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.541657	18,384	9,958	52.00
53.00	05300 ANESTHESIOLOGY	0.040501	598,368	24,235	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.600887	808,105	485,580	54.00
54.01	03630 ULTRA SOUND	0.128339	118,434	15,200	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.071833	233,318	16,760	54.02
55.00	03480 ONCOLOGY	0.474801	69,066	32,793	55.00
57.00	05700 CT SCAN	0.030636	1,497,668	45,883	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.110261	169,135	18,649	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.149260	3,202,428	477,994	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.191003	500,017	95,505	62.00
65.00	06500 RESPIRATORY THERAPY	0.142733	3,304,542	471,667	65.00
66.00	06600 PHYSICAL THERAPY	0.303823	545,891	165,854	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.348648	204,300	71,229	67.00
68.00	06800 SPEECH PATHOLOGY	0.288156	73,800	21,266	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03610 SLEEP LAB	0.222189	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270818	2,291,459	620,568	71.00
71.01	07101 IV SOLUTIONS	0.072715	664,934	48,351	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.339088	3,939,504	1,335,839	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.181758	10,573,075	1,921,741	73.00
76.00	03140 RADIOLOGY	0.125807	1,262,475	158,828	76.00
76.97	07697 CARDIAC REHABILITATION	0.258635	490	127	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1.662392	0	0	90.00
91.00	09100 EMERGENCY	0.183276	2,469,772	452,650	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.652540	337,406	220,171	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		36,124,735	7,217,685	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		36,124,735		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/28/2019 12:26 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		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		1,595,980	30.00
31.00	03100	INTENSIVE CARE UNIT		470,690	31.00
43.00	04300	NURSERY		926,821	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.176873	1,218,979	50.00
51.00	05100	RECOVERY ROOM	0.082273	343,792	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.541657	726,668	52.00
53.00	05300	ANESTHESIOLOGY	0.037771	572,624	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.600887	156,828	54.00
54.01	03630	ULTRA SOUND	0.128339	34,729	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.071833	51,660	54.02
55.00	03480	ONCOLOGY	0.474801	13,856	55.00
57.00	05700	CT SCAN	0.030636	301,038	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.110261	50,628	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.149260	985,414	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.191003	81,121	62.00
65.00	06500	RESPIRATORY THERAPY	0.142733	653,049	65.00
66.00	06600	PHYSICAL THERAPY	0.303823	81,952	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.348648	18,179	67.00
68.00	06800	SPEECH PATHOLOGY	0.288156	9,672	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	03610	SLEEP LAB	0.222189	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270818	735,011	71.00
71.01	07101	IV SOLUTIONS	0.072715	250,524	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.339088	669,514	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181758	4,272,313	73.00
76.00	03140	CARDIOLOGY	0.125807	282,308	76.00
76.97	07697	CARDIAC REHABILITATION	0.258635	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.662392	0	90.00
91.00	09100	EMERGENCY	0.171285	582,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.652540	40,136	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		12,132,283	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		12,132,283	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 12:26 pm
		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)		8,114,269	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,624,293	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)		77,636	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		81.72	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)		3.88	30.00
31.00	Percentage of Medicaid patient days (see instructions)		23.11	31.00
32.00	Sum of lines 30 and 31		26.99	32.00
33.00	Allowable disproportionate share percentage (see instructions)		11.48	33.00
34.00	Disproportionate share adjustment (see instructions)		308,197	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 12:26 pm
		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)	0.000109990	0.000138012	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	744,269	1,110,898	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	556,672	280,007	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	836,679		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)	11,961,074		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	12,007,369		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		12,007,369	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		891,806	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		8,442	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)		22,049	58.00
59.00	Total (sum of amounts on lines 49 through 58)		12,929,666	59.00
60.00	Primary payer payments		5,917	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		12,923,749	61.00
62.00	Deductibles billed to program beneficiaries		1,507,164	62.00
63.00	Coinurance billed to program beneficiaries		35,845	63.00
64.00	Allowable bad debts (see instructions)		84,368	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		54,839	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		34,325	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		11,435,579	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		3,700	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)		106,848	70.93
70.94	HRR adjustment amount (see instructions)		-198,697	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 12:26 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0 70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2019		135,776 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)			11,475,806 71.00
71.01	Sequestration adjustment (see instructions)			229,516 71.01
71.02	Demonstration payment adjustment amount after sequestration			0 71.02
72.00	Interim payments			11,653,706 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)			-407,416 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			625,964 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	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	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.			
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			
202.00	Medicare discharges (see instructions)			
203.00	Case-mix adjustment factor (see instructions)			
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			
205.00	Case-mix adjusted target amount (line 203 times line 204)			
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			
209.00	Adjustment to Medicare IPPS payments (see instructions)			
210.00	Reserved for future use			
211.00	Total adjustment to Medicare IPPS payments (see instructions)			
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			
213.00	Low-volume adjustment (see instructions)			
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0069

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/28/2019 12:26 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	8,114,269	8,114,269	0	0	8,114,269	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,624,293	0	0	2,624,293	2,624,293	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	77,636	70,229	0	7,407	77,636	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1148	0.1148	0.1148	0.1148	0.1148	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	308,197	232,880	0	75,317	308,197	11.00
11.01	Uncompensated care payments	36.00	836,679	632,212	0	204,467	836,679	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	11,961,074	9,049,590	0	2,911,484	11,961,074	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	12,007,369	9,021,066	0	2,986,303	12,007,369	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,007,369	9,021,066	0	2,986,303	12,007,369	15.00
16.00	Payment for inpatient program capital (From Wkst. L, Pt. I, if applicable)	50.00	891,806	677,668	0	214,138	891,806	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	3,700	3,700	0	0	3,700	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0069

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/28/2019 12:26 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			9,702,434	0	3,200,441	12,902,875	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	871,660	659,451	0	212,209	871,660	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	20,146	18,217	0	1,929	20,146	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	891,806	677,668	0	214,138	891,806	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.042424		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				135,776	135,776	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0069		Period: From 01/01/2018 To 12/31/2018		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2019 12:26 pm	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 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	8,114,269	8,114,269		8,114,269	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,624,293		2,624,293	2,624,293	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	77,636	70,229	7,406	77,635	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1148	0.1148	0.1148		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	308,197	232,880	75,317	308,197	11.00
11.01	Uncompensated care payments	36.00	836,679	556,672	280,007	836,679	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	11,961,074	8,974,051	2,987,023	11,961,074	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	12,007,369	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,007,369	12,007,369	0	12,007,369	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	891,806	677,668	214,138	891,806	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	3,700	3,700	0	3,700	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			12,688,737	214,138	12,902,875	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0069

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/28/2019 12:26 pm

		Title XVIII			Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	871,660	659,451	212,209	871,660	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	20,146	18,217	1,929	20,146	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	891,806	677,668	214,138	891,806	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	135,776		135,776	135,776	29.00	
30.00	HVBP payment adjustment (see instructions)	70.93	106,848	98,874	7,974	106,848	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	-198,697	-177,703	-20,994	-198,697	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: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 12:26 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,828	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		13,217,890	2.00
3.00	OPPS payments		13,856,096	3.00
4.00	Outlier payment (see instructions)		27,034	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		42,773	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		7,828	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		42,406	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)		42,406	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)		42,406	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		34,578	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)		7,828	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)		13,925,903	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		169	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,667,385	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)		11,266,177	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)		11,266,177	30.00
31.00	Primary payer payments		3,113	31.00
32.00	Subtotal (line 30 minus line 31)		11,263,064	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)		270,076	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		175,549	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		172,633	36.00
37.00	Subtotal (see instructions)		11,438,613	37.00
38.00	MSP-LCC reconciliation amount from PS&R		1,421	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)		11,437,192	40.00
40.01	Sequestration adjustment (see instructions)		228,744	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		11,270,817	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-62,369	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		192,202	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: 15-0069		Period: From 01/01/2018 To 12/31/2018		Worksheet E-1 Part I Date/Time Prepared: 5/28/2019 12:26 pm	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		11,653,706		11,270,817	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		11,653,706		11,270,817	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		407,416		62,369	6.02	
7.00	Total Medicare program liability (see instructions)		11,246,290		11,208,448	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: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/28/2019 12:26 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2019 12:26 pm	
		Title XIX	Hospital	Cost	
		Inpatient	Outpatient		
		1.00	2.00		
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	4,303,986		1.00	
2.00	Medical and other services		6,480,163	2.00	
3.00	Organ acquisition (certified transplant centers only)	0		3.00	
4.00	Subtotal (sum of lines 1, 2 and 3)	4,303,986	6,480,163	4.00	
5.00	Inpatient primary payer payments	0		5.00	
6.00	Outpatient primary payer payments		0	6.00	
7.00	Subtotal (line 4 less sum of lines 5 and 6)	4,303,986	6,480,163	7.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	0		8.00	
9.00	Ancillary service charges	12,132,283	33,358,203	9.00	
10.00	Organ acquisition charges, net of revenue	0		10.00	
11.00	Incentive from target amount computation	0		11.00	
12.00	Total reasonable charges (sum of lines 8 through 11)	12,132,283	33,358,203	12.00	
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00	
14.00	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	0	14.00	
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00	
16.00	Total customary charges (see instructions)	12,132,283	33,358,203	16.00	
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	7,828,297	26,878,040	17.00	
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00	
19.00	Interns and Residents (see instructions)	0	0	19.00	
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	4,303,986	6,480,163	21.00	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0	0	22.00	
23.00	Outlier payments	0	0	23.00	
24.00	Program capital payments	0		24.00	
25.00	Capital exception payments (see instructions)	0		25.00	
26.00	Routine and Ancillary service other pass through costs	0	0	26.00	
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00	
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00	
29.00	Titles V or XIX (sum of lines 21 and 27)	4,303,986	6,480,163	29.00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	0	0	30.00	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	4,303,986	6,480,163	31.00	
32.00	Deductibles	0	0	32.00	
33.00	Coinurance	0	0	33.00	
34.00	Allowable bad debts (see instructions)	0	0	34.00	
35.00	Utilization review	0		35.00	
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	4,303,986	6,480,163	36.00	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00	
38.00	Subtotal (line 36 ± line 37)	4,303,986	6,480,163	38.00	
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00	
40.00	Total amount payable to the provider (sum of lines 38 and 39)	4,303,986	6,480,163	40.00	
41.00	Interim payments	4,303,986	6,480,163	41.00	
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00	
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00	

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

Provider CCN: 15-0069

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

Worksheet G

Date/Time Prepared:
5/28/2019 12:26 pm

		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	19,687,624	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	7,268,715	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,507,284	0	0	0	7.00
8.00	Prepaid expenses	3,741,312	0	0	0	8.00
9.00	Other current assets	98,768	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)	33,303,703	0	0	0	11.00
FIXED ASSETS						
12.00	Land	4,039,775	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	118,174,706	0	0	0	15.00
16.00	Accumulated depreciation	-35,263,675	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	1,222,800	0	0	0	21.00
22.00	Accumulated depreciation	-1,054,272	0	0	0	22.00
23.00	Major movable equipment	64,499,565	0	0	0	23.00
24.00	Accumulated depreciation	-49,658,042	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	101,960,857	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	136,063,766	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	136,063,766	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	271,328,326	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,127,668	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	599,630	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	11,268,225	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,995,523	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	90,742,457	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,581,179	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	92,323,636	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	105,319,159	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	166,009,167				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)	166,009,167	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	271,328,326	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0069

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

Worksheet G-1

Date/Time Prepared:
5/28/2019 12:26 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		169,281,285		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-3,272,118			2.00
3.00	Total (sum of line 1 and line 2)		166,009,167		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)		166,009,167		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)		166,009,167		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: 15-0069

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	11,994,338		11,994,338	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)	11,994,338		11,994,338	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,796,557		2,796,557	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)	2,796,557		2,796,557	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,790,895		14,790,895	17.00
18.00	Ancillary services	73,602,116	296,117,005	369,719,121	18.00
19.00	Outpatient services	0	0	0	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		1,736,106	1,736,106	22.00
23.00	AMBULANCE SERVICES	0	5,207,462	5,207,462	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	318,742	318,742	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)	88,393,011	303,379,315	391,772,326	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		125,838,924		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)		125,838,924		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0069

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

Worksheet G-3

Date/Time Prepared:
5/28/2019 12:26 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	391,772,326	1.00
2.00	Less contractual allowances and discounts on patients' accounts	262,326,920	2.00
3.00	Net patient revenues (line 1 minus line 2)	129,445,406	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	125,838,924	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,606,482	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	260,063	6.00
7.00	Income from investments	3,351,012	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	414,193	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	6	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	52	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	60,199	23.00
24.00	OTHER OPERATING INCOME	-10,964,125	24.00
25.00	Total other income (sum of lines 6-24)	-6,878,600	25.00
26.00	Total (line 5 plus line 25)	-3,272,118	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,272,118	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0069

Period: From 01/01/2018

Worksheet H

HHA CCN: 15-7141

To 12/31/2018

Date/Time Prepared: 5/28/2019 12:26 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	869,676	0	1,878	0	12,404	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	30,793	0	0	6.00
7.00	Physical Therapy	0	0	28,817	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	1,620	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	20,089	12.00
13.00	Drugs	0	0	0	0	496	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	869,676	0	63,108	0	32,989	24.00
	Reclassified	Reclassified	Adjustments	Net Expenses			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	-290,309	593,649	0	593,649		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	2,485	33,278	0	33,278		6.00
7.00	Physical Therapy	213,234	242,051	0	242,051		7.00
8.00	Occupational Therapy	57,486	57,486	0	57,486		8.00
9.00	Speech Pathology	5,023	5,023	0	5,023		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	19,969	21,589	0	21,589		11.00
12.00	Supplies (see instructions)	0	20,089	0	20,089		12.00
13.00	Drugs	0	496	0	496		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Tel emedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	7,888	973,661	0	973,661		24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 15-0069 HHA CCN: 15-7141		Period: From 01/01/2018 To 12/31/2018		Worksheet H-1 Part I Date/Time Prepared: 5/28/2019 12:26 pm		
				Home Health Agency I		PPS		
	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	593,649	0	0	0	593,649	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	33,278	0	0	0	33,278	6.00	
7.00	Physical Therapy	242,051	0	0	0	242,051	7.00	
8.00	Occupational Therapy	57,486	0	0	0	57,486	8.00	
9.00	Speech Pathology	5,023	0	0	0	5,023	9.00	
10.00	Medical Social Services	0	0	0	0	0	10.00	
11.00	Home Health Aide	21,589	0	0	0	21,589	11.00	
12.00	Supplies (see instructions)	20,089	0	0	0	20,089	12.00	
13.00	Drugs	496	0	0	0	496	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
23.50	Tel emedicine	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	973,661	0	0	0	973,661	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	593,649					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	51,986	85,264				6.00	
7.00	Physical Therapy	378,128	620,179				7.00	
8.00	Occupational Therapy	89,804	147,290				8.00	
9.00	Speech Pathology	7,847	12,870				9.00	
10.00	Medical Social Services	0	0				10.00	
11.00	Home Health Aide	33,726	55,315				11.00	
12.00	Supplies (see instructions)	31,383	51,472				12.00	
13.00	Drugs	775	1,271				13.00	
14.00	DME	0	0				14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
23.50	Tel emedicine	0	0				23.50	
24.00	Total (sum of lines 1-23)		973,661				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0069

Period: From 01/01/2018

Worksheet H-1

HHA CCN: 15-7141

To 12/31/2018

Part II
Date/Time Prepared:
5/28/2019 12:26 pm

Home Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-593,649	380,012
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	33,278
7.00	Physical Therapy	0	0	0	0	0	242,051
8.00	Occupational Therapy	0	0	0	0	0	57,486
9.00	Speech Pathology	0	0	0	0	0	5,023
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	21,589
12.00	Supplies (see instructions)	0	0	0	0	0	20,089
13.00	Drugs	0	0	0	0	0	496
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-593,649	380,012
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		593,649
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		1.562185

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0069

Period: From 01/01/2018

Worksheet H-2 Part I

HHA CCN: 15-7141

To 12/31/2018

Date/Time Prepared: 5/28/2019 12:26 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP				
		1.00	1.01	2.00	4.00			
	0					4A		
1.00 Administrative and General	0	0	6,207	0	219,531	225,738	1.00	
2.00 Skilled Nursing Care	85,264	0	0	0	0	85,264	2.00	
3.00 Physical Therapy	620,179	0	0	0	0	620,179	3.00	
4.00 Occupational Therapy	147,290	0	0	0	0	147,290	4.00	
5.00 Speech Pathology	12,870	0	0	0	0	12,870	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	55,315	0	0	0	0	55,315	7.00	
8.00 Supplies (see instructions)	51,472	0	0	0	0	51,472	8.00	
9.00 Drugs	1,271	0	0	0	0	1,271	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
19.50 Telemedicine	0	0	0	0	0	0	19.50	
20.00 Total (sum of lines 1-19) (2)	973,661	0	6,207	0	219,531	1,199,399	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.000000	21.00	
Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
	5.00	7.00	8.00	9.00	10.00	11.00		
1.00 Administrative and General	35,816	49,867	0	0	0	0	1.00	
2.00 Skilled Nursing Care	13,528	0	0	0	0	0	2.00	
3.00 Physical Therapy	98,397	0	0	0	0	0	3.00	
4.00 Occupational Therapy	23,369	0	0	0	0	0	4.00	
5.00 Speech Pathology	2,042	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	8,776	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	8,167	0	0	0	0	0	8.00	
9.00 Drugs	202	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
19.50 Telemedicine	0	0	0	0	0	0	19.50	
20.00 Total (sum of lines 1-19) (2)	190,297	49,867	0	0	0	0	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00	

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0069

Period: From 01/01/2018

Worksheet H-2

HHA CCN: 15-7141

To 12/31/2018

Part I
Date/Time Prepared:
5/28/2019 12:26 pm

Home Health Agency I

PPS

Cost Center Description		NURSING	CENTRAL	PHARMACY	MEDICAL	NONPHYSICIAN	RADIOLOGY	
		ADMINISTRATION	SERVICES & SUPPLY		RECORDS & LIBRARY	ANESTHETISTS	SCHOOL	
		13.00	14.00	15.00	16.00	19.00	23.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	793	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	793	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	311,421	0	311,421				1.00
2.00	Skilled Nursing Care	98,792	0	98,792	27,252	126,044		2.00
3.00	Physical Therapy	718,576	0	718,576	198,222	916,798		3.00
4.00	Occupational Therapy	170,659	0	170,659	47,077	217,736		4.00
5.00	Speech Pathology	14,912	0	14,912	4,114	19,026		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	64,091	0	64,091	17,680	81,771		7.00
8.00	Supplies (see instructions)	60,432	0	60,432	16,670	77,102		8.00
9.00	Drugs	1,473	0	1,473	406	1,879		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	1,440,356	0	1,440,356	311,421	1,440,356		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.275854			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2018 To 12/31/2018	Worksheet H-2 Part II Date/Time Prepared: 5/28/2019 12:26 pm
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		Home Health Agency I	PPS
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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	1.01	2.00				
1.00 Administrative and General	0	2,748	2,748	877,564	0	225,738	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	85,264	2.00
3.00 Physical Therapy	0	0	0	0	0	620,179	3.00
4.00 Occupational Therapy	0	0	0	0	0	147,290	4.00
5.00 Speech Pathology	0	0	0	0	0	12,870	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	55,315	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	51,472	8.00
9.00 Drugs	0	0	0	0	0	1,271	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	2,748	2,748	877,564	0	1,199,399	20.00
21.00 Total cost to be allocated	0	6,207	0	219,531	0	190,297	21.00
22.00 Unit cost multiplier	0.000000	2.258734	0.000000	0.250160	0	0.158660	22.00
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	2,748	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	2,748	0	0	0	0	0	20.00
21.00 Total cost to be allocated	49,867	0	0	0	0	0	21.00
22.00 Unit cost multiplier	18.146652	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0069

HHA CCN: 15-7141

Period:

From 01/01/2018
To 12/31/2018

Worksheet H-2

Part II
Date/Time Prepared:
5/28/2019 12:26 pm

Home Health
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PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	RADIOLOGY SCHOOL (ASSIGNED TIME)		
		14.00	15.00	16.00	19.00	23.00		
1.00	Administrative and General	0	0	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0	0		7.00
8.00	Supplies (see instructions)	25,670	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Tel emedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19)	25,670	0	0	0	0		20.00
21.00	Total cost to be allocated	793	0	0	0	0		21.00
22.00	Unit cost multiplier	0.030892	0.000000	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet H-3 Part I Date/Time Prepared: 5/28/2019 12:26 pm
		HHA CCN: 15-7141	Title XVIII	Home Health Agency I PPS

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	126,044		126,044	3,721	33.87	1.00
2.00	Physical Therapy	3.00	916,798	0	916,798	2,957	310.04	2.00
3.00	Occupational Therapy	4.00	217,736	0	217,736	653	333.44	3.00
4.00	Speech Pathology	5.00	19,026	0	19,026	42	453.00	4.00
5.00	Medical Social Services	6.00	0		0	2	0.00	5.00
6.00	Home Health Aide	7.00	81,771		81,771	186	439.63	6.00
7.00	Total (sum of lines 1-6)		1,361,375	0	1,361,375	7,561		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 ÷ col. 4)
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	1,967		8.00
9.00	Physical Therapy		99915	0	1,881		9.00
10.00	Occupational Therapy		99915	0	415		10.00
11.00	Speech Pathology		99915	0	12		11.00
12.00	Medical Social Services		99915	0	1		12.00
13.00	Home Health Aide		99915	0	143		13.00
14.00	Total (sum of lines 8-13)			0	4,419		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	77,102	0	77,102	0	0.000000	15.00
16.00	Cost of Drugs	9.00	1,879	0	1,879	0	0.000000	16.00

Cost Center Description	Part A	Program Visits		Cost of Services	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,967		0	66,622	1.00
2.00	Physical Therapy	0	1,881		0	583,185	2.00
3.00	Occupational Therapy	0	415		0	138,378	3.00
4.00	Speech Pathology	0	12		0	5,436	4.00
5.00	Medical Social Services	0	1		0	0	5.00
6.00	Home Health Aide	0	143		0	62,867	6.00
7.00	Total (sum of lines 1-6)	0	4,419		0	856,488	7.00

Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00
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Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS			Provider CCN: 15-0069 HHA CCN: 15-7141		Period: From 01/01/2018 To 12/31/2018		Worksheet H-3 Part I Date/Time Prepared: 5/28/2019 12:26 pm	
			Title XVIII		Home Health Agency I		PPS	
Cost Center Description	Program Covered Charges				Cost of Services			
	Part A	Part B		Part A		Part B		
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	285	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of col.s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	66,622						1.00
2.00	Physical Therapy	583,185						2.00
3.00	Occupational Therapy	138,378						3.00
4.00	Speech Pathology	5,436						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	62,867						6.00
7.00	Total (sum of lines 1-6)	856,488						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2018 To 12/31/2018	Worksheet H-3 Part II Date/Time Prepared: 5/28/2019 12:26 pm
Title XVIII			Home Health Agency I	PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.303823	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.348648	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.288156	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.270818	0	0	col. 2, line 15.00	4.00
4.01	Cost of Medical Supplies 1	71.01	0.072715	0	0	col. 2, line 15.01	4.01
5.00	Cost of Drugs	73.00	0.181758	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2018 To 12/31/2018	Worksheet H-4 Part I-11 Date/Time Prepared: 5/28/2019 12:26 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	1,776	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	-1,776
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	793,528
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	10,446
13.00	Total PPS Reimbursement - LUPA Episodes		0	13,623
14.00	Total PPS Reimbursement - PEP Episodes		0	13,938
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	2,882
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	832,641
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	832,641
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	832,641
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	832,641
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	832,641
31.01	Sequestration adjustment (see instructions)		0	16,652
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	815,989
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0069
HHA CCN: 15-7141

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

Worksheet H-5
Date/Time Prepared:
5/28/2019 12:26 pm
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		815,989	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		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			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			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		815,989	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		815,989	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPI CE COSTS

Provider CCN: 15-0069

Period: From 01/01/2018

Worksheet 0

Hospice CCN: 15-1535

To 12/31/2018

Date/Time Prepared: 5/28/2019 12:26 pm

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0 2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0 3.00
4.00	ADMINISTRATIVE & GENERAL*	45,558	4,093	49,651	41,118	90,769 4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0 5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0 6.00
7.00	HOUSEKEEPING*	0	0	0	0	0 7.00
8.00	DIETARY*	0	0	0	0	0 8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0 9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0 10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0 11.00
12.00	STAFF TRANSPORTATION*	0	299	299	0	299 12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	80	80 13.00
14.00	PHARMACY*	0	11,803	11,803	0	11,803 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0 15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0 25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0 26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0 27.00
28.00	REGISTERED NURSE**	0	5,637	5,637	20	5,657 28.00
29.00	LPN/LVN**	0	0	0	0	0 29.00
30.00	PHYSICAL THERAPY**	0	472	472	30	502 30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0 31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0 32.00
33.00	MEDICAL SOCIAL SERVICES**	0	1,090	1,090	160	1,250 33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0 34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0 35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0 36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	2,069	2,069	5,614	7,683 37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	43,725	43,725	0	43,725 38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0 39.00
40.00	IMAGING SERVICES**	0	0	0	0	0 40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0 41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0 42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0 42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0 43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0 44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0 45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0 46.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0 60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0 61.00
62.00	FUNDRAISING*	0	0	0	0	0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0 63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0 64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0 65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0 66.00
67.00	ADVERTISING*	0	0	0	0	0 67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0 68.00
69.00	THRIFT STORE*	0	0	0	0	0 69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0 70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0 71.00
100.00	TOTAL	45,558	69,188	114,746	47,022	161,768 100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2018

Worksheet 0

Hospice CCN: 15-1535

To 12/31/2018

Date/Time Prepared: 5/28/2019 12:26 pm

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	90,769	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	299	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	80	13.00
14.00	PHARMACY*	0	11,803	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	5,657	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	502	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	1,250	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	7,683	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	43,725	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	161,768	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE	Provider CCN: 15-0069 Hospice CCN: 15-1535	Period: From 01/01/2018 To 12/31/2018	Worksheet 0-2 Date/Time Prepared: 5/28/2019 12:26 pm
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		SALARIES	OTHER	SubTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFICATIONS	SubTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	5,586	5,586	20	5,606	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	467	467	30	497	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	1,080	1,080	158	1,238	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	2,050	2,050	5,563	7,613	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	43,725	43,725	0	43,725	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	52,908	52,908	5,771	58,679	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	5,606	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	497	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	1,238	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	7,613	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	43,725	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	58,679	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPIRE CARE	Provider CCN: 15-0069 Hospice CCN: 15-1535	Period: From 01/01/2018 To 12/31/2018	Worksheet 0-3 Date/Time Prepared: 5/28/2019 12:26 pm
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		SALARIES	OTHER	SubTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFICATIONS	SubTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	21	21	0	21	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	2	2	0	2	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	4	4	1	5	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	8	8	21	29	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	35	35	22	57	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	21	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	2	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	5	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	29	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	57	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE	Provider CCN: 15-0069 Hospice CCN: 15-1535	Period: From 01/01/2018 To 12/31/2018	Worksheet 0-4 Date/Time Prepared: 5/28/2019 12:26 pm
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		SALARIES	OTHER	SubTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFI- CATIONS	SubTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	30	30	0	30	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	3	3	0	3	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	6	6	1	7	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	11	11	30	41	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	50	50	31	81	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	30	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	3	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	7	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	41	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	81	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-0069
Hospice CCN: 15-1535

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

Worksheet 0-5
Date/Time Prepared:
5/28/2019 12:26 pm

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	1,680	1,680	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	23,160	23,160	3.00
4.00	ADMINISTRATIVE & GENERAL	90,769	29,607	120,376	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	13,501	13,501	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	299	0	299	12.00
13.00	VOLUNTEER SERVICE COORDINATION	80	0	80	13.00
14.00	PHARMACY	11,803	0	11,803	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	58,679	0	58,679	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	57	0	57	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	81	0	81	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	161,768	67,948	229,716	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2018

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2018

Part I
Date/Time Prepared:
5/28/2019 12:26 pm

Descriptions	Hospice I				SUBTOTAL	
	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT		
	0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,680	1,680			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	23,160	0	0	23,160	3.00
4.00	ADMINISTRATIVE & GENERAL	120,376	1,680	0	20,158	4.00
5.00	PLANT OPERATION & MAINTENANCE	13,501	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	299	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	80	0	0	41	13.00
14.00	PHARMACY	11,803	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	50.00
51.00	HOSPICE ROUTINE HOME CARE	58,679			2,934	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	57	0	0	11	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	81	0	0	16	53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	99.00
100.00	TOTAL	229,716	1,680	0	23,160	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2018

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2018

Part I
Date/Time Prepared:
5/28/2019 12:26 pm

Descriptions	Hospice I					
	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00 ADMINISTRATIVE & GENERAL	142,214					4.00
5.00 PLANT OPERATION & MAINTENANCE	21,943	35,444				5.00
6.00 LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00 HOUSEKEEPING	0	0		0		7.00
8.00 DIETARY	0	0		0	0	8.00
9.00 NURSING ADMINISTRATION	0	0		0		9.00
10.00 ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00 MEDICAL RECORDS	0	0		0		11.00
12.00 STAFF TRANSPORTATION	486	0		0		12.00
13.00 VOLUNTEER SERVICE COORDINATION	197	0		0		13.00
14.00 PHARMACY	19,183	0		0		14.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00 OTHER GENERAL SERVICE	0	0		0		16.00
17.00 PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
LEVEL OF CARE						
50.00 HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00 HOSPICE ROUTINE HOME CARE	100,136					51.00
52.00 HOSPICE INPATIENT RESPIRE CARE	111	14,886	0	0	0	52.00
53.00 HOSPICE GENERAL INPATIENT CARE	158	20,558	0	0	0	53.00
NONREIMBURSABLE COST CENTERS						
60.00 BEREAVEMENT PROGRAM	0	0		0		60.00
61.00 VOLUNTEER PROGRAM	0	0		0		61.00
62.00 FUNDRAISING	0	0		0		62.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00 PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00 OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00 RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00 ADVERTISING	0	0		0		67.00
68.00 TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00 THIRFT STORE	0	0		0		69.00
70.00 NURSING FACILITY ROOM & BOARD						70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00 NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00 TOTAL	142,214	35,444	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2018

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2018

Part I
Date/Time Prepared:
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Descriptions	Hospice I					
	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
	9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00	NURSING ADMINISTRATION	0				9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0			10.00
11.00	MEDICAL RECORDS	0		0		11.00
12.00	STAFF TRANSPORTATION	0			785	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	318 13.00
14.00	PHARMACY	0			0	0 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0 15.00
16.00	OTHER GENERAL SERVICE	0			0	0 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					0 17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0 50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0	778	310 51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	3	4 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	4	4 53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0 60.00
61.00	VOLUNTEER PROGRAM	0			0	0 61.00
62.00	FUNDRAISING	0			0	0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0 63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0 64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0 65.00
66.00	RESIDENTIAL CARE	0			0	0 66.00
67.00	ADVERTISING	0			0	0 67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0 68.00
69.00	THRIFT STORE	0			0	0 69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0 71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0 99.00
100.00	TOTAL	0	0	0	785	318 100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2018

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2018

Part I
Date/Time Prepared:
5/28/2019 12:26 pm

Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00	30,986					14.00
15.00	0	0				15.00
16.00	0		0			16.00
17.00				0		17.00
LEVEL OF CARE						
50.00	0	0	0		0	50.00
51.00	30,703	0	0		193,540	51.00
52.00	118	0	0	0	15,190	52.00
53.00	165	0	0	0	20,986	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0		0		0	60.00
61.00	0		0		0	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		0	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	0	66.00
67.00	0		0		0	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00	0		0		0	70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	30,986	0	0	0	229,716	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0069

Period: From 01/01/2018

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2018

Part II
Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	HOSPICE I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIX	744					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	45,558			3.00
4.00	ADMINISTRATIVE & GENERAL	744	0	39,654	-142,214	87,502	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	13,501	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	299	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	80	0	121	13.00
14.00	PHARMACY	0	0	0	0	11,803	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			5,771	0	61,613	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	22	0	68	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	31	0	97	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	1,680	0	23,160		142,214	100.00
101.00	UNIT COST MULTIPLIER	2.258065	0.000000	0.508363		1.625266	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPI CE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0069

Period: From 01/01/2018

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2018

Part II
Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	100					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPI TE CARE	42	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	58	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	35,444	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	354.440000	0.000000	0.000000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0069

Period: From 01/01/2018

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2018

Part II
Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	0					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			9,265			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	80		13.00
14.00	PHARMACY			0	0	11,804	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	9,181	78	11,696	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	35	1	45	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	49	1	63	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	785	318	30,986	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.084727	3.975000	2.625042	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0069
Hospice CCN: 15-1535

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

Worksheet 0-6
Part II
Date/Time Prepared:
5/28/2019 12:26 pm

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER		0			99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-0069

Period: From 01/01/2018

Worksheet 0-7

Hospice CCN: 15-1535

To 12/31/2018

Date/Time Prepared: 5/28/2019 12:26 pm

Hospice I

Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)				
			HCHC	HRHC	HIRC		
			2.00	3.00	4.00		
ANCI LLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.303823	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.348648	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.288156	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.181758	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.149260	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.270818	0	0	0	7.00
7.01	IV SOLUTIONS	71.01	0.072715	0	0	0	7.01
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	ONCOLOGY	55.00	0.474801	0	0	0	9.00
10.00	CARDIOLOGY	76.00	0.125807	0	0	0	10.00
10.97	CARDIAC REHABILITATION	76.97	0.258635	0	0	0	10.97
11.00	Totals (sum of lines 1-11)						11.00

Cost Center Descriptions	Charges by LOC (from Provider Records)	Shared Service Costs by LOC					
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
ANCI LLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
7.01	IV SOLUTIONS	0	0	0	0	0	7.01
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	ONCOLOGY	0	0	0	0	0	9.00
10.00	CARDIOLOGY	0	0	0	0	0	10.00
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97
11.00	Totals (sum of lines 1-11)						11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0069

Period: From 01/01/2018

Worksheet 0-8

Hospice CCN: 15-1535

To 12/31/2018

Date/Time Prepared: 5/28/2019 12:26 pm

		Hospice I		
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID	TOTAL
		1.00	2.00	3.00
HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0
3.00	Total average cost per diem (line 1 divided by line 2)			0.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0	0
5.00	Program cost (line 3 times line 4)	0	0	0
HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			193,540
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			1,613
8.00	Total average cost per diem (line 6 divided by line 7)			119.99
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	1,306	160	1,466
10.00	Program cost (line 8 times line 9)	156,707	19,198	175,905
HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			15,190
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			5
13.00	Total average cost per diem (line 11 divided by line 12)			3,038.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	5	0	5
15.00	Program cost (line 13 times line 14)	15,190	0	15,190
HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			20,986
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			7
18.00	Total average cost per diem (line 16 divided by line 17)			2,998.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	7	0	7
20.00	Program cost (line 18 times line 19)	20,986	0	20,986
TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			229,716
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			1,625
23.00	Average cost per diem (line 21 divided by line 22)			141.36

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0069	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/28/2019 12:26 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		871,660	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		20,146	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		30.46	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)		891,806	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00