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: 15-3039	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 3:39 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2019 Time: 3:39 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 COMMUNITY HOWARD SPECIALITY HOSPITAL (15-3039) 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.

[X] 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) HOLLY MILLARD
Officer or Administrator of Provider(s)

NETWORK SENIOR VICE PRESIDENT OF FIN
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	16,520	232	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
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	16,520	232	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 3:39 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 829 NORTH DIXON ROAD	PO Box:			1.00
2.00	City: KOKOMO	State: IN	Zip Code: 46901	County: HOWARD	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		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	COMMUNITY HOWARD SPECIALITY HOSPITAL	153039	29020	5	04/01/2004	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	6		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.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 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.	N	N	N	22.03
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.	0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:39 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.	155	6	0	0	273		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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 Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 3:39 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:39 pm

		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	
	Inpatient Psychiatric Facility PPS				
70.00	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)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			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)	N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-3039	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:39 pm

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 3:39 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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	37,330	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0720	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 3:39 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: COMMUNITY HEALTH NETWORK	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 1500 N. RITTER	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46219-3095	143.00

		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.			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
161.10	CORF		N	N	N	161.10

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	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	166.00

		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.	N	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)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2019 3:39 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	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	N	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	05/01/2019	Y	05/01/2019	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 3:39 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 relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DEBORAH	THOMPSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH NETWORK		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-621-7927	DTHOMPSON4@ECOMMUNITY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-3039	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 3:39 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.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 3:39 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P 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	30	10,950	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)		30	10,950	0.00	0	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)		30	10,950	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.)	115.00					23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC	99.00				0	25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		30				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: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 3:39 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,205	161	4,866			1.00
2.00	HMO and other (see instructions)	0	273				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)	3,205	161	4,866			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)	3,205	161	4,866	0.00	100.76	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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC	0	0	0	0.00	0.00	25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC						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	100.76	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 3:39 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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	273	15	405	1.00
2.00	HMO and other (see instructions)			28	20		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	273	15	405	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.)	0.00					23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC	0.00					25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC						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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 3:39 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	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	1,157,473	1,157,473	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,052,967	2,294,621	3,347,588	-26,553	3,321,035	5.00
7.00	00700	OPERATION OF PLANT	56,831	1,166,072	1,222,903	-740,240	482,663	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,458	24,458	0	24,458	8.00
9.00	00900	HOUSEKEEPING	111,461	84,819	196,280	0	196,280	9.00
10.00	01000	DIETARY	128,416	140,956	269,372	-5,627	263,745	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	103,002	12,417	115,419	-183	115,236	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,582,782	1,255,621	3,838,403	-1,865,020	1,973,383	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,430	2,999	9,429	35,186	44,615	54.00
57.00	05700	CT SCAN	0	6	6	21,141	21,147	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,408	12,408	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	20,558	20,558	0	20,558	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	346,099	96,196	442,295	1,161	443,456	65.00
66.00	06600	PHYSICAL THERAPY	1,316,842	1,141,867	2,458,709	559,509	3,018,218	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	591,361	591,361	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	156,338	156,338	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	12,216	12,216	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-1,861	-1,861	107,228	105,367	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	120,449	200,384	320,833	867	321,700	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT	0	0	0	0	0	93.00
93.02	04952	NEUROPSYCH	0	125	125	-125	0	93.02
93.03	04953	SLEEP LAB	233,749	138,768	372,517	-17,140	355,377	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,059,028	6,578,006	12,637,034	0	12,637,034	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	PROJECT ACCESS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	6,059,028	6,578,006	12,637,034	0	12,637,034	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 3:39 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,157,473		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	237,517	237,517		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,009,242	4,330,277		5.00
7.00	00700	OPERATION OF PLANT	0	482,663		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,458		8.00
9.00	00900	HOUSEKEEPING	0	196,280		9.00
10.00	01000	DIETARY	-760	262,985		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	14,832	130,068		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	10,995	1,984,378		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	-11,537	33,078		54.00
57.00	05700	CT SCAN	-14,080	7,067		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-1,949	10,459		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	217,420	237,978		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	-577	442,879		65.00
66.00	06600	PHYSICAL THERAPY	-16,240	3,001,978		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	591,361		67.00
68.00	06800	SPEECH PATHOLOGY	18,787	175,125		68.00
69.00	06900	ELECTROCARDIOLOGY	-6,034	6,182		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,720	120,087		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,308	334,008		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT	0	0		93.00
93.02	04952	NEUROPSYCH	0	0		93.02
93.03	04953	SLEEP LAB	71,101	426,478		93.03
93.04	04954	PHYSICIANS OFFICE	0	0		93.04
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0	0		94.00
95.00	09500	AMBULANCE SERVICES	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
98.00	09851	OTHER REIMBURSABLE	0	0		98.00
99.00	09900	CMHC	0	0		99.00
99.10	09910	CORF	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
105.00	10500	KIDNEY ACQUISITION	0	0		105.00
106.00	10600	HEART ACQUISITION	0	0		106.00
107.00	10700	LIVER ACQUISITION	0	0		107.00
108.00	10800	LUNG ACQUISITION	0	0		108.00
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
113.00	11300	INTEREST EXPENSE	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,555,745	14,192,779		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	PROJECT ACCESS	0	0		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	1,555,745	14,192,779		200.00

RECLASSIFICATIONS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 3:39 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - Chargeable Medical Supplies				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	107,228	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
	0		0	107,228	
	C - Drugs Charges to Pat				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,908	1.00
	0		0	1,908	
	D - Depreciation Expense				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	110,377	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
	0		0	110,377	
	F - Other Capital Rental				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,047,096	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
	0		0	1,047,096	
	J - Purchased Service Reclass				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	35,186	1.00
2.00	CT SCAN	57.00	0	21,141	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	12,408	3.00
4.00	RESPIRATORY THERAPY	65.00	0	1,161	4.00
5.00	ELECTROCARDIOLOGY	69.00	0	12,083	5.00
6.00	ELECTROCARDIOLOGY	69.00	0	133	6.00
	0		0	82,112	
	K - Therapy				
1.00	PHYSICAL THERAPY	66.00	638,300	274,150	1.00
2.00	OCCUPATIONAL THERAPY	67.00	413,684	177,677	2.00
3.00	SPEECH PATHOLOGY	68.00	109,366	46,972	3.00
	0		1,161,350	498,799	
500.00	Grand Total: Increases		1,161,350	1,847,520	500.00

RECLASSIFICATIONS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 3:39 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - Chargeable Medical Supplies					
1.00	OPERATION OF PLANT	7.00	0	17,219	0	1.00
2.00	DIETARY	10.00	0	53	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	76,208	0	3.00
4.00	PHYSICAL THERAPY	66.00	0	3,724	0	4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	555	0	5.00
6.00	SLEEP LAB	93.03	0	9,469	0	6.00
	0		0	107,228		
	C - Drugs Charges to Pat					
1.00	ADULTS & PEDIATRICS	30.00	0	1,908	0	1.00
	0		0	1,908		
	D - Depreciation Expense					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	23,237	9	1.00
2.00	OPERATION OF PLANT	7.00	0	33,242	0	2.00
3.00	DIETARY	10.00	0	5,541	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	183	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	20,869	0	5.00
6.00	PHYSICAL THERAPY	66.00	0	19,023	0	6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	486	0	7.00
8.00	NEUROPSYCH	93.02	0	125	0	8.00
9.00	SLEEP LAB	93.03	0	7,671	0	9.00
	0		0	110,377		
	F - Other Capital Rental					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,316	10	1.00
2.00	OPERATION OF PLANT	7.00	0	689,779	0	2.00
3.00	DIETARY	10.00	0	33	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	23,774	0	4.00
5.00	PHYSICAL THERAPY	66.00	0	330,194	0	5.00
	0		0	1,047,096		
	J - Purchased Service Reclass					
1.00	ADULTS & PEDIATRICS	30.00	0	82,112	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
	0		0	82,112		
	K - Therapy					
1.00	ADULTS & PEDIATRICS	30.00	1,161,350	498,799	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		1,161,350	498,799		
500.00	Grand Total: Decreases		1,161,350	1,847,520		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2019 3:39 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	703,862	2,000	0	2,000	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	904,064	70,482	0	70,482	2,300	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,607,926	72,482	0	72,482	2,300	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	1,607,926	72,482	0	72,482	2,300	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	705,862	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	972,246	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,678,108	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	1,678,108	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2019 3:39 pm

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

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	0		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2019 3:39 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	705,862	0	705,862	0.420630	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	972,246	0	972,246	0.579370	0	2.00
3.00	Total (sum of lines 1-2)	1,678,108	0	1,678,108	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	110,377	1,047,096	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	110,377	1,047,096	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,157,473	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,157,473	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 3:39 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-158,385			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	1,757,790			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC. REVENUE - SALES	B	0	PHYSICAL THERAPY	66.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 3:39 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	Misc Revenue	B	-760	DIETARY	10.00	0	33.01
33.02	Misc Revenue	B	-9,881	PHYSICAL THERAPY	66.00	0	33.02
33.03	MISC INCOME - SALES	B	-1,693	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	Purchased Discounts	B	-462	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	Space Rental Income	B	-5,005	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	Space Rental Income	B	-2,681	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	Interest Income	B	-11,188	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	Misc. Revenue - Sales	B	-4,112	PHYSICAL THERAPY	66.00	0	33.08
34.00	Charitable Contributions-Offset	A	-325	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	Advertising Expense Offset	A	-5,306	ADMINISTRATIVE & GENERAL	5.00	0	34.01
34.02	Advertising Expense Offset	A	-2,247	PHYSICAL THERAPY	66.00	0	34.02
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,555,745				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2019 3:39 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	CHRH ADMINISTRATIVE	377,926	628,252	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	CHRH PURCHASED SVC	23,585	35,186	2.00
3.00	57.00	CT SCAN	CHRH PURCHASED SVC	7,061	21,141	3.00
3.01	58.00	MAGNETIC RESONANCE IMAGING (	CHRH PURCHASED SVC	10,459	12,408	3.01
3.02	60.00	LABORATORY	CHRH PURCHASED SVC	217,420	0	3.02
3.03	65.00	RESPIRATORY THERAPY	CHRH PURCHASED SVC	584	1,161	3.03
3.04	68.00	SPEECH PATHOLOGY	CHRH PURCHASED SVC	18,787	0	3.04
3.05	69.00	ELECTROCARDIOLOGY	CHRH PURCHASED SVC	6,043	12,083	3.05
3.06	71.00	MEDICAL SUPPLIES CHARGED TO	CHRH PURCHASED SVC	1,574	0	3.06
3.07	73.00	DRUGS CHARGED TO PATIENTS	CHRH PURCHASED SVC	6,561	133	3.07
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CHNW HOME OFFICE	237,517	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	CHNW HOME OFFICE	1,420,574	0	4.01
4.02	13.00	NURSING ADMINISTRATION	CHNW HOME OFFICE	14,832	0	4.02
4.03	30.00	ADULTS & PEDIATRICS	CHNW HOME OFFICE	13,676	0	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	CHNW HOME OFFICE	64	0	4.04
4.05	69.00	ELECTROCARDIOLOGY	CHNW HOME OFFICE	6	0	4.05
4.06	93.03	SLEEP LAB	CHNW HOME OFFICE	92,459	0	4.06
4.07	71.00	MEDICAL SUPPLIES CHARGED TO	CHNW HOME OFFICE	13,146	0	4.07
4.08	73.00	DRUGS CHARGED TO PATIENTS	CHNW HOME OFFICE	5,880	0	4.08
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,468,154	710,364	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	G	COMMUNITY HOWAR	60.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	MISC SERVICES				100.00

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2019 3:39 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-250,326	0		1.00
2.00	-11,601	0		2.00
3.00	-14,080	0		3.00
3.01	-1,949	0		3.01
3.02	217,420	0		3.02
3.03	-577	0		3.03
3.04	18,787	0		3.04
3.05	-6,040	0		3.05
3.06	1,574	0		3.06
3.07	6,428	0		3.07
4.00	237,517	0		4.00
4.01	1,420,574	0		4.01
4.02	14,832	0		4.02
4.03	13,676	0		4.03
4.04	64	0		4.04
4.05	6	0		4.05
4.06	92,459	0		4.06
4.07	13,146	0		4.07
4.08	5,880	0		4.08
5.00	1,757,790			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2019 3:39 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	AGGREGATE-ADMINISTRATIVE & GENERAL	413,502	0	413,502	211,500	2,719	1.00
2.00	93.03	AGGREGATE-SLEEP LAB	36,000	0	36,000	211,500	144	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			449,502	0	449,502		2,863	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	276,475	13,824	0	0	0	1.00
2.00	93.03	AGGREGATE-SLEEP LAB	14,642	732	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			291,117	14,556	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	276,475	137,027	137,027		1.00
2.00	93.03	AGGREGATE-SLEEP LAB	0	14,642	21,358	21,358		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	291,117	158,385	158,385		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 3:39 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,157,473	1,157,473				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	237,517	3,995	0	241,512		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,330,277	91,410	0	41,971	4,463,658	5.00
7.00	00700	OPERATION OF PLANT	482,663	443,040	0	2,265	927,968	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,458	14,579	0	0	39,037	8.00
9.00	00900	HOUSEKEEPING	196,280	9,186	0	4,443	209,909	9.00
10.00	01000	DIETARY	262,985	118,197	0	5,119	386,301	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	130,068	6,671	0	4,106	140,845	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,097	0	0	7,097	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,984,378	214,413	0	56,658	2,255,449	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,078	1,379	0	256	34,713	54.00
57.00	05700	CT SCAN	7,067	0	0	0	7,067	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,459	0	0	0	10,459	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	237,978	0	0	0	237,978	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	442,879	1,947	0	13,796	458,622	65.00
66.00	06600	PHYSICAL THERAPY	3,001,978	104,692	0	77,932	3,184,602	66.00
67.00	06700	OCCUPATIONAL THERAPY	591,361	43,029	0	16,489	650,879	67.00
68.00	06800	SPEECH PATHOLOGY	175,125	6,245	0	4,359	185,729	68.00
69.00	06900	ELECTROCARDIOLOGY	6,182	0	0	0	6,182	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	120,087	22,062	0	0	142,149	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	334,008	14,194	0	4,801	353,003	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	OTHER OUTPATIENT	0	0	0	0	0	93.00
93.02	04952	NEUROPSYCH	0	0	0	0	0	93.02
93.03	04953	SLEEP LAB	426,478	11,234	0	9,317	447,029	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,192,779	1,113,370	0	241,512	14,148,676	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	17,499	0	0	17,499	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	PROJECT ACCESS	0	26,604	0	0	26,604	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,192,779	1,157,473	0	241,512	14,192,779	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 3:39 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,463,658					5.00
7.00	00700	OPERATION OF PLANT	425,746	1,353,714				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,910	31,883	88,830			8.00
9.00	00900	HOUSEKEEPING	96,305	20,088	0	326,302		9.00
10.00	01000	DIETARY	177,233	258,477	0	64,791	886,802	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	64,619	14,589	0	3,657	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,256	15,520	0	3,890	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,034,786	468,887	88,830	117,533	886,802	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,926	3,015	0	756	0	54.00
57.00	05700	CT SCAN	3,242	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,799	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	109,183	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	210,413	4,257	0	1,067	0	65.00
66.00	06600	PHYSICAL THERAPY	1,461,073	228,945	0	57,389	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	298,619	94,097	0	23,587	0	67.00
68.00	06800	SPEECH PATHOLOGY	85,211	13,658	0	3,424	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,836	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	65,217	48,246	0	12,093	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	161,956	31,040	0	7,781	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT	0	0	0	0	0	93.00
93.02	04952	NEUROPSYCH	0	0	0	0	0	93.02
93.03	04953	SLEEP LAB	205,094	24,566	0	6,158	0	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,443,424	1,257,268	88,830	302,126	886,802	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,028	38,268	0	9,593	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	PROJECT ACCESS	12,206	58,178	0	14,583	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,463,658	1,353,714	88,830	326,302	886,802	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 3:39 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	223,710				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	29,763			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	134,223	8,929	4,995,439	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,186	0	65,596	0	54.00
57.00	05700	CT SCAN	0	0	0	10,309	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	15,258	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	11,186	0	358,347	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	22,371	1,488	698,218	0	65.00
66.00	06600	PHYSICAL THERAPY	0	11,186	7,441	4,950,636	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,186	7,441	1,085,809	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,186	1,488	300,696	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	9,018	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	267,705	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	553,780	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	OTHER OUTPATIENT	0	0	0	0	0	93.00
93.02	04952	NEUROPSYCH	0	0	0	0	0	93.02
93.03	04953	SLEEP LAB	0	11,186	2,976	697,009	0	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	223,710	29,763	14,007,820	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	73,388	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	PROJECT ACCESS	0	0	0	111,571	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	223,710	29,763	14,192,779	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 3:39 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	4,995,439		30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,596		54.00
57.00	05700	CT SCAN	10,309		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,258		58.00
59.00	05900	CARDIAC CATHETERIZATION	0		59.00
60.00	06000	LABORATORY	358,347		60.00
60.01	06001	BLOOD LABORATORY	0		60.01
65.00	06500	RESPIRATORY THERAPY	698,218		65.00
66.00	06600	PHYSICAL THERAPY	4,950,636		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,085,809		67.00
68.00	06800	SPEECH PATHOLOGY	300,696		68.00
69.00	06900	ELECTROCARDIOLOGY	9,018		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	267,705		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	553,780		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	OTHER OUTPATIENT	0		93.00
93.02	04952	NEUROPSYCH	0		93.02
93.03	04953	SLEEP LAB	697,009		93.03
93.04	04954	PHYSICIANS OFFICE	0		93.04
		OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	0		94.00
95.00	09500	AMBULANCE SERVICES	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		97.00
98.00	09851	OTHER REIMBURSABLE	0		98.00
99.00	09900	CMHC	0		99.00
99.10	09910	CORF	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		100.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
105.00	10500	KIDNEY ACQUISITION	0		105.00
106.00	10600	HEART ACQUISITION	0		106.00
107.00	10700	LIVER ACQUISITION	0		107.00
108.00	10800	LUNG ACQUISITION	0		108.00
109.00	10900	PANCREAS ACQUISITION	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0		110.00
111.00	11100	ISLET ACQUISITION	0		111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		115.00
116.00	11600	HOSPICE	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,007,820		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	73,388		192.00
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	PROJECT ACCESS	111,571		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	14,192,779		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/29/2019 3:39 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,995	0	3,995	3,995	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	91,410	0	91,410	694	5.00
7.00	00700	OPERATION OF PLANT	0	443,040	0	443,040	37	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,579	0	14,579	0	8.00
9.00	00900	HOUSEKEEPING	0	9,186	0	9,186	73	9.00
10.00	01000	DIETARY	0	118,197	0	118,197	85	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,671	0	6,671	68	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,097	0	7,097	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	214,413	0	214,413	937	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,379	0	1,379	4	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	1,947	0	1,947	228	65.00
66.00	06600	PHYSICAL THERAPY	0	104,692	0	104,692	1,291	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	43,029	0	43,029	273	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,245	0	6,245	72	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,062	0	22,062	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,194	0	14,194	79	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	OTHER OUTPATIENT	0	0	0	0	0	93.00
93.02	04952	NEUROPSYCH	0	0	0	0	0	93.02
93.03	04953	SLEEP LAB	0	11,234	0	11,234	154	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,113,370	0	1,113,370	3,995	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	17,499	0	17,499	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	PROJECT ACCESS	0	26,604	0	26,604	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,157,473	0	1,157,473	3,995	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 3:39 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	92,104					5.00
7.00	00700	OPERATION OF PLANT	8,785	451,862				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	370	10,642	25,591			8.00
9.00	00900	HOUSEKEEPING	1,987	6,705	0	17,951		9.00
10.00	01000	DIETARY	3,657	86,278	0	3,564	211,781	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,333	4,870	0	201	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	67	5,181	0	214	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,352	156,511	25,591	6,466	211,781	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	329	1,007	0	42	0	54.00
57.00	05700	CT SCAN	67	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	99	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,253	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	4,342	1,421	0	59	0	65.00
66.00	06600	PHYSICAL THERAPY	30,146	76,420	0	3,157	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,162	31,409	0	1,298	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,758	4,559	0	188	0	68.00
69.00	06900	ELECTROCARDIOLOGY	59	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,346	16,104	0	665	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,342	10,361	0	428	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT	0	0	0	0	0	93.00
93.02	04952	NEUROPSYCH	0	0	0	0	0	93.02
93.03	04953	SLEEP LAB	4,232	8,200	0	339	0	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	91,686	419,668	25,591	16,621	211,781	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	166	12,774	0	528	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	PROJECT ACCESS	252	19,420	0	802	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	92,104	451,862	25,591	17,951	211,781	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 3:39 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	13,143				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	12,559			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,887	3,767	648,705	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	657	0	3,418	0	54.00
57.00	05700	CT SCAN	0	0	0	67	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	99	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	657	0	2,910	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	1,314	628	9,939	0	65.00
66.00	06600	PHYSICAL THERAPY	0	657	3,140	219,503	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	657	3,140	85,968	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	657	628	14,107	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	59	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	40,177	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,404	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	OTHER OUTPATIENT	0	0	0	0	0	93.00
93.02	04952	NEUROPSYCH	0	0	0	0	0	93.02
93.03	04953	SLEEP LAB	0	657	1,256	26,072	0	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	13,143	12,559	1,079,428	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	30,967	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	PROJECT ACCESS	0	0	0	47,078	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	13,143	12,559	1,157,473	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 3:39 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	648,705		30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,418		54.00
57.00	05700	CT SCAN	67		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	99		58.00
59.00	05900	CARDIAC CATHETERIZATION	0		59.00
60.00	06000	LABORATORY	2,910		60.00
60.01	06001	BLOOD LABORATORY	0		60.01
65.00	06500	RESPIRATORY THERAPY	9,939		65.00
66.00	06600	PHYSICAL THERAPY	219,503		66.00
67.00	06700	OCCUPATIONAL THERAPY	85,968		67.00
68.00	06800	SPEECH PATHOLOGY	14,107		68.00
69.00	06900	ELECTROCARDIOLOGY	59		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,177		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,404		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	OTHER OUTPATIENT	0		93.00
93.02	04952	NEUROPSYCH	0		93.02
93.03	04953	SLEEP LAB	26,072		93.03
93.04	04954	PHYSICIANS OFFICE	0		93.04
		OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	0		94.00
95.00	09500	AMBULANCE SERVICES	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		97.00
98.00	09851	OTHER REIMBURSABLE	0		98.00
99.00	09900	CMHC	0		99.00
99.10	09910	CORF	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		100.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
105.00	10500	KIDNEY ACQUISITION	0		105.00
106.00	10600	HEART ACQUISITION	0		106.00
107.00	10700	LIVER ACQUISITION	0		107.00
108.00	10800	LUNG ACQUISITION	0		108.00
109.00	10900	PANCREAS ACQUISITION	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0		110.00
111.00	11100	ISLET ACQUISITION	0		111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		115.00
116.00	11600	HOSPICE	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,079,428		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,967		192.00
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	PROJECT ACCESS	47,078		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,157,473		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 3:39 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	57,082					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	197	0	6,059,028			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,508	0	1,052,967	-4,463,658	9,729,121	5.00
7.00	00700	OPERATION OF PLANT	21,849	0	56,831	0	927,968	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	719	0	0	0	39,037	8.00
9.00	00900	HOUSEKEEPING	453	0	111,461	0	209,909	9.00
10.00	01000	DIETARY	5,829	0	128,416	0	386,301	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	329	0	103,002	0	140,845	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	350	0	0	0	7,097	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,574	0	1,421,432	0	2,255,449	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	68	0	6,430	0	34,713	54.00
57.00	05700	CT SCAN	0	0	0	0	7,067	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	10,459	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	237,978	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	96	0	346,099	0	458,622	65.00
66.00	06600	PHYSICAL THERAPY	5,163	0	1,955,142	0	3,184,602	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,122	0	413,684	0	650,879	67.00
68.00	06800	SPEECH PATHOLOGY	308	0	109,366	0	185,729	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	6,182	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,088	0	0	0	142,149	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	700	0	120,449	0	353,003	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT	0	0	0	0	0	93.00
93.02	04952	NEUROPSYCH	0	0	0	0	0	93.02
93.03	04953	SLEEP LAB	554	0	233,749	0	447,029	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,907	0	6,059,028	-4,463,658	9,685,018	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	863	0	0	0	17,499	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	PROJECT ACCESS	1,312	0	0	0	26,604	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,157,473	0	241,512		4,463,658	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.277373	0.000000	0.039860		0.458794	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 3:39 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			3,995		92,104	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000659		0.009467	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: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 3:39 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MANHOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	30,528					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	719	100				8.00
9.00	00900	HOUSEKEEPING	453	0	29,356			9.00
10.00	01000	DIETARY	5,829	0	5,829	4,866		10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	329	0	329	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	350	0	350	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,574	100	10,574	4,866	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	68	0	68	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	96	0	96	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,163	0	5,163	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,122	0	2,122	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	308	0	308	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,088	0	1,088	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	700	0	700	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT	0	0	0	0	0	93.00
93.02	04952	NEUROPSYCH	0	0	0	0	0	93.02
93.03	04953	SLEEP LAB	554	0	554	0	0	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,353	100	27,181	4,866	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	863	0	863	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	PROJECT ACCESS	1,312	0	1,312	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,353,714	88,830	326,302	886,802	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44.343357	888.300000	11.115343	182.244554	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	451,862	25,591	17,951	211,781	0	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 3:39 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MANHOURS)	
			7.00	8.00	9.00	10.00	11.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	14.801559	255.910000	0.611493	43.522606	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: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 3:39 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
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	100			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,000		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	60	300		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	5	0		54.00
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	5	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	10	50		65.00
66.00	06600	PHYSICAL THERAPY	5	250		66.00
67.00	06700	OCCUPATIONAL THERAPY	5	250		67.00
68.00	06800	SPEECH PATHOLOGY	5	50		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT	0	0		93.00
93.02	04952	NEUROPSYCH	0	0		93.02
93.03	04953	SLEEP LAB	5	100		93.03
93.04	04954	PHYSICIANS OFFICE	0	0		93.04
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0	0		94.00
95.00	09500	AMBULANCE SERVICES	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
98.00	09851	OTHER REIMBURSABLE	0	0		98.00
99.00	09900	CMHC	0	0		99.00
99.10	09910	CORF	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
105.00	10500	KIDNEY ACQUISITION	0	0		105.00
106.00	10600	HEART ACQUISITION	0	0		106.00
107.00	10700	LIVER ACQUISITION	0	0		107.00
108.00	10800	LUNG ACQUISITION	0	0		108.00
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	1,000		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	PROJECT ACCESS	0	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	223,710	29,763		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2,237.100000	29.763000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,143	12,559		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 3:39 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	16.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	131.430000	12.559000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 3:39 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,995,439		4,995,439	0	4,995,439	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,596		65,596	0	65,596	54.00
57.00	05700	CT SCAN	10,309		10,309	0	10,309	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,258		15,258	0	15,258	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	358,347		358,347	0	358,347	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	698,218	0	698,218	0	698,218	65.00
66.00	06600	PHYSICAL THERAPY	4,950,636	0	4,950,636	0	4,950,636	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,085,809	0	1,085,809	0	1,085,809	67.00
68.00	06800	SPEECH PATHOLOGY	300,696	0	300,696	0	300,696	68.00
69.00	06900	ELECTROCARDIOLOGY	9,018		9,018	0	9,018	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	267,705		267,705	0	267,705	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	553,780		553,780	0	553,780	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0		0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	OTHER OUTPATIENT	0		0	0	0	93.00
93.02	04952	NEUROPSYCH	0		0	0	0	93.02
93.03	04953	SLEEP LAB	697,009		697,009	21,358	718,367	93.03
93.04	04954	PHYSICIANS OFFICE	0		0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0		0	0	0	98.00
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		0		0	100.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0		0		0	105.00
106.00	10600	HEART ACQUISITION	0		0		0	106.00
107.00	10700	LIVER ACQUISITION	0		0		0	107.00
108.00	10800	LUNG ACQUISITION	0		0		0	108.00
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	14,007,820	0	14,007,820	21,358	14,029,178	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	14,007,820	0	14,007,820	21,358	14,029,178	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/29/2019 3:39 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,151,811		8,151,811			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	208,496	1,021	209,517	0.313082	0.000000	54.00
57.00	05700	CT SCAN	168,510	0	168,510	0.061177	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	84,738	0	84,738	0.180061	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	2,168,217	0	2,168,217	0.165273	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	1,284,793	0	1,284,793	0.543448	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,143,610	13,985,710	17,129,320	0.289015	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,176,689	367,042	3,543,731	0.306403	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	779,538	208,518	988,056	0.304331	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	30,486	0	30,486	0.295808	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	167,028	39,967	206,995	1.293292	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,650,741	0	1,650,741	0.335474	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
93.00	04040	OTHER OUTPATIENT	0	0	0	0.000000	0.000000	93.00
93.02	04952	NEUROPSYCH	0	0	0	0.000000	0.000000	93.02
93.03	04953	SLEEP LAB	0	1,886,297	1,886,297	0.369512	0.000000	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	0.000000	0.000000	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
98.00	09851	OTHER REIMBURSABLE	0	0	0	0.000000	0.000000	98.00
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0	0	0			105.00
106.00	10600	HEART ACQUISITION	0	0	0			106.00
107.00	10700	LIVER ACQUISITION	0	0	0			107.00
108.00	10800	LUNG ACQUISITION	0	0	0			108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	21,014,657	16,488,555	37,503,212			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	21,014,657	16,488,555	37,503,212			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 3:39 pm

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.313082		54.00
57.00	05700	CT SCAN	0.061177		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.180061		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.165273		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.543448		65.00
66.00	06600	PHYSICAL THERAPY	0.289015		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306403		67.00
68.00	06800	SPEECH PATHOLOGY	0.304331		68.00
69.00	06900	ELECTROCARDIOLOGY	0.295808		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.293292		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.335474		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	OTHER OUTPATIENT	0.000000		93.00
93.02	04952	NEUROPSYCH	0.000000		93.02
93.03	04953	SLEEP LAB	0.380835		93.03
93.04	04954	PHYSICIANS OFFICE	0.000000		93.04
		OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
98.00	09851	OTHER REIMBURSABLE	0.000000		98.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
105.00	10500	KIDNEY ACQUISITION			105.00
106.00	10600	HEART ACQUISITION			106.00
107.00	10700	LIVER ACQUISITION			107.00
108.00	10800	LUNG ACQUISITION			108.00
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 3:39 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	4,995,439		4,995,439	0	4,995,439	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,596		65,596	0	65,596	54.00
57.00	05700	CT SCAN	10,309		10,309	0	10,309	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,258		15,258	0	15,258	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	358,347		358,347	0	358,347	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	698,218	0	698,218	0	698,218	65.00
66.00	06600	PHYSICAL THERAPY	4,950,636	0	4,950,636	0	4,950,636	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,085,809	0	1,085,809	0	1,085,809	67.00
68.00	06800	SPEECH PATHOLOGY	300,696	0	300,696	0	300,696	68.00
69.00	06900	ELECTROCARDIOLOGY	9,018		9,018	0	9,018	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	267,705		267,705	0	267,705	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	553,780		553,780	0	553,780	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0		0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	OTHER OUTPATIENT	0		0	0	0	93.00
93.02	04952	NEUROPSYCH	0		0	0	0	93.02
93.03	04953	SLEEP LAB	697,009		697,009	21,358	718,367	93.03
93.04	04954	PHYSICIANS OFFICE	0		0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0		0	0	0	98.00
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		0		0	100.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0		0		0	105.00
106.00	10600	HEART ACQUISITION	0		0		0	106.00
107.00	10700	LIVER ACQUISITION	0		0		0	107.00
108.00	10800	LUNG ACQUISITION	0		0		0	108.00
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	14,007,820	0	14,007,820	21,358	14,029,178	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	14,007,820	0	14,007,820	21,358	14,029,178	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 3:39 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,151,811		8,151,811			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	208,496	1,021	209,517	0.313082	0.000000	54.00
57.00	05700	CT SCAN	168,510	0	168,510	0.061177	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	84,738	0	84,738	0.180061	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	2,168,217	0	2,168,217	0.165273	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	1,284,793	0	1,284,793	0.543448	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,143,610	13,985,710	17,129,320	0.289015	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,176,689	367,042	3,543,731	0.306403	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	779,538	208,518	988,056	0.304331	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	30,486	0	30,486	0.295808	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	167,028	39,967	206,995	1.293292	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,650,741	0	1,650,741	0.335474	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
93.00	04040	OTHER OUTPATIENT	0	0	0	0.000000	0.000000	93.00
93.02	04952	NEUROPSYCH	0	0	0	0.000000	0.000000	93.02
93.03	04953	SLEEP LAB	0	1,886,297	1,886,297	0.369512	0.000000	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	0.000000	0.000000	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
98.00	09851	OTHER REIMBURSABLE	0	0	0	0.000000	0.000000	98.00
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0	0	0			105.00
106.00	10600	HEART ACQUISITION	0	0	0			106.00
107.00	10700	LIVER ACQUISITION	0	0	0			107.00
108.00	10800	LUNG ACQUISITION	0	0	0			108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	21,014,657	16,488,555	37,503,212			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	21,014,657	16,488,555	37,503,212			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/29/2019 3:39 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	OTHER OUTPATIENT	0.000000		93.00
93.02	04952	NEUROPSYCH	0.000000		93.02
93.03	04953	SLEEP LAB	0.000000		93.03
93.04	04954	PHYSICIANS OFFICE	0.000000		93.04
		OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
98.00	09851	OTHER REIMBURSABLE	0.000000		98.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
105.00	10500	KIDNEY ACQUISITION			105.00
106.00	10600	HEART ACQUISITION			106.00
107.00	10700	LIVER ACQUISITION			107.00
108.00	10800	LUNG ACQUISITION			108.00
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/29/2019 3:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	648,705	0	648,705	4,866	133.31	30.00
200.00	Total (lines 30 through 199)	648,705		648,705	4,866		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	3,205	427,259	30.00
200.00	Total (lines 30 through 199)	3,205	427,259	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 3:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,418	209,517	0.016314	144,616	2,359	54.00
57.00	05700	CT SCAN	67	168,510	0.000398	103,026	41	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	99	84,738	0.001168	65,042	76	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	2,910	2,168,217	0.001342	1,458,510	1,957	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	9,939	1,284,793	0.007736	886,713	6,860	65.00
66.00	06600	PHYSICAL THERAPY	219,503	17,129,320	0.012814	2,165,735	27,752	66.00
67.00	06700	OCCUPATIONAL THERAPY	85,968	3,543,731	0.024259	2,082,200	50,512	67.00
68.00	06800	SPEECH PATHOLOGY	14,107	988,056	0.014278	485,631	6,934	68.00
69.00	06900	ELECTROCARDIOLOGY	59	30,486	0.001935	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,177	206,995	0.194096	110,145	21,379	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,404	1,650,741	0.017207	946,586	16,288	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT	0	0	0.000000	0	0	93.00
93.02	04952	NEUROPSYCH	0	0	0.000000	0	0	93.02
93.03	04953	SLEEP LAB	26,072	1,886,297	0.013822	0	0	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0.000000	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)	430,723	29,351,401		8,448,204	134,158	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/29/2019 3:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,866	0.00	3,205	30.00
200.00		Total (lines 30 through 199)		0	4,866		3,205	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	OTHER OUTPATIENT	0	0	0	0	0	93.00
93.02	04952	NEUROPSYCH	0	0	0	0	0	93.02
93.03	04953	SLEEP LAB	0	0	0	0	0	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	209,517	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	168,510	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	84,738	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	2,168,217	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,284,793	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	17,129,320	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,543,731	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	988,056	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	30,486	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	206,995	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,650,741	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0.000000	92.00
93.00	04040	OTHER OUTPATIENT	0	0	0	0	0.000000	93.00
93.02	04952	NEUROPSYCH	0	0	0	0	0.000000	93.02
93.03	04953	SLEEP LAB	0	0	0	1,886,297	0.000000	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	0	0.000000	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00
98.00	09851	OTHER REIMBURSABLE	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	29,351,401		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	144,616	0	1,012	0	54.00
57.00	05700	CT SCAN	0.000000	103,026	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	65,042	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,458,510	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	886,713	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,165,735	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,082,200	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	485,631	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	110,145	0	5,345	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	946,586	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT	0.000000	0	0	0	0	93.00
93.02	04952	NEUROPSYCH	0.000000	0	0	0	0	93.02
93.03	04953	SLEEP LAB	0.000000	0	0	558,796	0	93.03
93.04	04954	PHYSICIANS OFFICE	0.000000	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		8,448,204	0	565,153	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 3:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.313082	1,012	0	0	317	54.00
57.00	05700	CT SCAN	0.061177	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.180061	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.165273	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.543448	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.289015	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306403	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.304331	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.295808	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.293292	5,345	0	328	6,913	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.335474	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT	0.000000	0	0	0	0	93.00
93.02	04952	NEUROPSYCH	0.000000	0	0	0	0	93.02
93.03	04953	SLEEP LAB	0.369512	558,796	0	0	206,482	93.03
93.04	04954	PHYSICIANS OFFICE	0.000000	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0			94.00
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		565,153	0	328	213,712	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		565,153	0	328	213,712	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 3:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
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
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	424	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	OTHER OUTPATIENT	0	0	93.00
93.02	04952	NEUROPSYCH	0	0	93.02
93.03	04953	SLEEP LAB	0	0	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0	0	98.00
200.00		Subtotal (see instructions)	0	424	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	424	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 3:39 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.313082	0	0	0	0	54.00
57.00	05700	CT SCAN	0.061177	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.180061	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.165273	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.543448	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.289015	0	83,484	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306403	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.304331	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.295808	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.293292	0	554	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.335474	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT	0.000000	0	0	0	0	93.00
93.02	04952	NEUROPSYCH	0.000000	0	0	0	0	93.02
93.03	04953	SLEEP LAB	0.369512	0	21,004	0	0	93.03
93.04	04954	PHYSICIANS OFFICE	0.000000	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0			94.00
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	105,042	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	105,042	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 3:39 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
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
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	24,128	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	716	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT	0	0		93.00
93.02	04952	NEUROPSYCH	0	0		93.02
93.03	04953	SLEEP LAB	7,761	0		93.03
93.04	04954	PHYSICIANS OFFICE	0	0		93.04
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0	0		94.00
95.00	09500	AMBULANCE SERVICES	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
98.00	09851	OTHER REIMBURSABLE	0	0		98.00
200.00		Subtotal (see instructions)	32,605	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	32,605	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 3:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,866	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,866	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,866	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,205	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)	4,995,439	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)	4,995,439	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)	4,995,439	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,026.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,290,253	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)	3,290,253	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 3:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,657,946	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,948,199	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)	427,259	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	134,158	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	561,417	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,386,782	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 3:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	648,705	4,995,439	0.129859	0	0	90.00
91.00	Nursing School cost	0	4,995,439	0.000000	0	0	91.00
92.00	Allied health cost	0	4,995,439	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,995,439	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 3:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,274,557		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.313082	144,616	45,277	54.00
57.00	05700	CT SCAN	0.061177	103,026	6,303	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.180061	65,042	11,712	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.165273	1,458,510	241,052	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.543448	886,713	481,882	65.00
66.00	06600	PHYSICAL THERAPY	0.289015	2,165,735	625,930	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306403	2,082,200	637,992	67.00
68.00	06800	SPEECH PATHOLOGY	0.304331	485,631	147,793	68.00
69.00	06900	ELECTROCARDIOLOGY	0.295808	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.293292	110,145	142,450	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.335474	946,586	317,555	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT	0.000000	0	0	93.00
93.02	04952	NEUROPSYCH	0.000000	0	0	93.02
93.03	04953	SLEEP LAB	0.380835	0	0	93.03
93.04	04954	PHYSICIANS OFFICE	0.000000	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,448,204	2,657,946	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)		8,448,204		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 3:39 pm

Title XIX | Hospital | Cost

		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		263,058		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.313082	2,314	724	54.00
57.00	05700	CT SCAN	0.061177	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.180061	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.165273	38,799	6,412	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.543448	12,626	6,862	65.00
66.00	06600	PHYSICAL THERAPY	0.289015	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306403	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.304331	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.295808	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.293292	2,252	2,912	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.335474	30,926	10,375	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT	0.000000	0	0	93.00
93.02	04952	NEUROPSYCH	0.000000	0	0	93.02
93.03	04953	SLEEP LAB	0.369512	0	0	93.03
93.04	04954	PHYSICIANS OFFICE	0.000000	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
98.00	09851	OTHER REIMBURSABLE	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		86,917	27,285	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)		86,917		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3039	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 3:39 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	424	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	213,712	2.00
3.00	OPPS payments	165,927	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	424	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	328	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)	328	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	328	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	96	20.00
21.00	Lesser of cost or charges (see instructions)	328	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)	165,927	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	33,341	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)	132,914	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)	132,914	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	132,914	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	132,914	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	132,914	40.00
40.01	Sequestration adjustment (see instructions)	2,658	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	130,024	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	232	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2019 3:39 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		4,886,351		130,024	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)		4,886,351		130,024	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		16,520		232	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,902,871		130,256	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	Provider CCN: 15-3039	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part III Date/Time Prepared: 5/29/2019 3:39 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4,891,709	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0236	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	168,764	3.00
4.00	Outlier Payments	57,936	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	13.331507	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	5,118,409	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	5,118,409	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	5,118,409	19.00
20.00	Deductibles	105,764	20.00
21.00	Subtotal (line 19 minus line 20)	5,012,645	21.00
22.00	Coinsurance	9,715	22.00
23.00	Subtotal (line 21 minus line 22)	5,002,930	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	5,002,930	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	5,002,930	32.00
32.01	Sequestration adjustment (see instructions)	100,059	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	4,886,351	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	16,520	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	57,936	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/29/2019 3:39 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	1,014,509	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	7,464,449	0	0	0	4.00
5.00	Other receivable	-4,699,865	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	112,174	0	0	0	7.00
8.00	Prepaid expenses	2,863	0	0	0	8.00
9.00	Other current assets	20,585	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)	3,914,715	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	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	705,862	0	0	0	15.00
16.00	Accumulated depreciation	0	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	972,246	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	-812,525	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)	865,583	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	570,703	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	570,703	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	5,351,001	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	201,556	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)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	78,464	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	280,020	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	280,020	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	5,070,981				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)	5,070,981	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	5,351,001	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/29/2019 3:39 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		4,486,965		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		584,018				2.00
3.00	Total (sum of line 1 and line 2)		5,070,983		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		5,070,983		0		11.00
12.00	ROUNDING	2		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		2		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,070,981		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	ROUNDING		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: 15-3039 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/29/2019 3:39 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	8,818,845		8,818,845	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)	8,818,845		8,818,845	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,818,845		8,818,845	17.00
18.00	Ancillary services	12,235,175	16,845,856	29,081,031	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		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	21,054,020	16,845,856	37,899,876	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		12,637,034		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)		12,637,034		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-3039	Period: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 5/29/2019 3:39 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	37,899,876	1.00
2.00	Less contractual allowances and discounts on patients' accounts	24,714,559	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,185,317	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	12,637,034	4.00
5.00	Net income from service to patients (line 3 minus line 4)	548,283	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	11,188	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	462	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	4,112	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	7,686	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	12,287	24.00
25.00	Total other income (sum of lines 6-24)	35,735	25.00
26.00	Total (line 5 plus line 25)	584,018	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)	584,018	29.00