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: 15-0149	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/22/2019 8:09 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/22/2019 Time: 8:09 am
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 DEACONESS WOMEN'S HOSPITAL (15-0149) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII 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	26,874	19,202	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
200.00	Total	0	26,874	19,202	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: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2019 8:09 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 4199 GATEWAY BLVD	PO Box:			1.00
2.00	City: NEWBURGH	State: IN	Zip Code: 47630-	County: WARRICK	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	DEACONESS WOMEN'S HOSPITAL	150149	21780	1	05/03/2001	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		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.	Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 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.	768	20	50	28	10,826	159	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2019 8:09 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural 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: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2019 8:09 am

		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: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2019 8:09 am

		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)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2019 8:09 am

		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.					109.00

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

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	368,975	4,731	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	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	HB0778	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2019 8:09 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: DEACONESS HEALTH SYSTEM	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 600 MARY ST	PO Box:		142.00
143.00	City: EVANSVILLE	State: IN	Zip Code: 47710	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

		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.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2018	12/31/2018	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: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/22/2019 8:09 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/29/2019	Y	04/29/2019	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/22/2019 8:09 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	09/30/2018	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.	DANIELLE	METZGER-CUNDIFF	41.00
42.00	Enter the employer/company name of the cost report preparer.	DEACONESS HOSPITAL, INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(812) 450-7423	DANIELLE.METZGER-CUNDIFF@DEACONESS.C	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0149	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/22/2019 8:09 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT ANALYST		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: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/22/2019 8:09 am

	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	50	18,250	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)		50	18,250	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	24	8,760	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		74	27,010	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		74				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: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2019 8:09 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	61	351	9,087			1.00
2.00	HMO and other (see instructions)	0	10,826				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)	61	351	9,087			7.00
8.00	INTENSIVE CARE UNIT	0	228	7,258			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		287	6,058			13.00
14.00	Total (see instructions)	61	866	22,403	0.00	509.38	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	509.38	27.00
28.00	Observation Bed Days		637	1,686			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	159	368			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: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2019 8:09 am

	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	36	144	3,648	1.00
2.00	HMO and other (see instructions)			0	1,393		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	36	144	3,648	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/22/2019 8:09 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	38,629,911	-215,224	38,414,687	1,059,512.00	36.26	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		1,391,696	125,000	1,516,696	9,478.77	160.01	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		3,976,731	0	3,976,731	30,604.73	129.94	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,608,234	617,004	4,225,238	82,828.54	51.01	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		1,441,750	0	1,441,750	7,150.25	201.64	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		3,590,422	0	3,590,422	121,102.00	29.65	14.01
14.02	Related organization salaries		554,898	0	554,898	16,392.37	33.85	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,000,150	0	8,000,150			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,062,663	0	1,062,663			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		157,136	0	157,136			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		387,627	0	387,627			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,047,206	0	1,047,206			25.50
25.51	Related organization wage-related (core)		92,229	0	92,229			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	325,868	18,598	344,466	9,190.00	37.48	26.00
27.00	Administrative & General	5.00	5,681,618	-750,616	4,931,002	137,386.45	35.89	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/22/2019 8:09 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		122,750	0	122,750	401.81	305.49	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	749,739	-6,162	743,577	40,874.75	18.19	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	634,809	-14,299	620,510	38,825.52	15.98	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	144,815	144,815	8,176.38	17.71	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	790,699	-404,402	386,297	21,810.76	17.71	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	105,844	-1,262	104,582	5,197.00	20.12	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	251,386	-1,851	249,535	12,946.50	19.27	41.00
42.00	Social Service	17.00	448,671	-8,283	440,388	16,206.30	27.17	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 5/22/2019 8:09 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		34,775,930	-215,224	34,560,706	1,029,309.08	33.58	1.00
2.00	Excluded area salaries (see instructions)		3,608,234	617,004	4,225,238	82,828.54	51.01	2.00
3.00	Subtotal salaries (line 1 minus line 2)		31,167,696	-832,228	30,335,468	946,480.54	32.05	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,587,070	0	5,587,070	144,644.62	38.63	4.00
5.00	Subtotal wage-related costs (see inst.)		9,296,721	0	9,296,721	0.00	30.65	5.00
6.00	Total (sum of lines 3 thru 5)		46,051,487	-832,228	45,219,259	1,091,125.16	41.44	6.00
7.00	Total overhead cost (see instructions)		9,111,384	-1,023,462	8,087,922	291,015.47	27.79	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 5/22/2019 8:09 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	842,232	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	4,823,505	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	278,314	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	32,223	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	639,421	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	106,366	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,628,053	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	81,185	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	39,890	21.00
22.00	Day Care Cost and Allowances	27,728	22.00
23.00	Tuition Reimbursement	108,659	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,607,576	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V | Date/Time Prepared: 5/22/2019 8:09 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	9,607,576	1.00
2.00	Hospital	0	9,607,576	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/22/2019 8:09 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.456275	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	14,663,792	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	45,382,430	6.00
7.00	Medicaid cost (line 1 times line 6)	20,706,868	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	6,043,076	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	6,043,076	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	464,138	184,738	648,876	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	211,775	184,738	396,513	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	1,188	1,188	22.00
23.00	Cost of charity care (line 21 minus line 22)	211,775	183,550	395,325	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,073,542	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	26,525	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	40,808	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,032,734	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	941,769	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,337,094	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,380,170	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/22/2019 8:09 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	4,393,144	4,393,144	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	3,777,387	3,777,387	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	325,868	9,328,820	9,654,688	18,344	9,673,032	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,681,618	14,846,240	20,527,858	-6,338,038	14,189,820	5.00
7.00	00700	OPERATION OF PLANT	749,739	1,518,242	2,267,981	-33,459	2,234,522	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	875,695	875,695	8.00
9.00	00900	HOUSEKEEPING	634,809	1,102,456	1,737,265	-882,198	855,067	9.00
10.00	01000	DIETARY	0	0	0	239,157	239,157	10.00
11.00	01100	CAFETERIA	790,699	516,897	1,307,596	-669,638	637,958	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	105,844	54,348	160,192	-6,552	153,640	14.00
15.00	01500	PHARMACY	0	2,965,393	2,965,393	-1,806,553	1,158,840	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	251,386	89,495	340,881	-1,283	339,598	16.00
17.00	01700	SOCIAL SERVICE	448,671	15,975	464,646	-797	463,849	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,037,998	887,049	8,925,047	-3,689,861	5,235,186	30.00
31.00	03100	INTENSIVE CARE UNIT	5,478,965	1,706,999	7,185,964	-297,343	6,888,621	31.00
43.00	04300	NURSERY	979,161	173,748	1,152,909	-144,925	1,007,984	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,050,944	7,475,111	11,526,055	-4,124,221	7,401,834	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,219,760	3,219,760	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,599,958	1,406,687	3,006,645	-845,355	2,161,290	54.00
60.00	06000	LABORATORY	0	2,747,547	2,747,547	-1,275	2,746,272	60.00
65.00	06500	RESPIRATORY THERAPY	1,162,632	363,589	1,526,221	-209,811	1,316,410	65.00
66.00	06600	PHYSICAL THERAPY	0	1,392,967	1,392,967	-55,883	1,337,084	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,009,498	3,009,498	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	587,335	587,335	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,737,713	1,737,713	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,998,440	955,328	3,953,768	-168,529	3,785,239	90.00
91.00	09100	EMERGENCY	1,724,945	403,735	2,128,680	769,143	2,897,823	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,021,677	47,950,626	82,972,303	-648,545	82,323,758	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	425,306	425,306	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,885,515	509,805	3,395,320	217,906	3,613,226	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	295,882	266,550	562,432	-8,900	553,532	194.01
194.02	07952	MARKETING	292,188	874,557	1,166,745	23,414	1,190,159	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	3,418	3,418	13,396	16,814	194.03
194.04	07954	CENTER FOR HEALING ARTS	134,649	43,771	178,420	-22,577	155,843	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	38,629,911	49,648,727	88,278,638	0	88,278,638	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/22/2019 8:09 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-87,613	4,305,531		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	3,777,387		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,773,589	13,446,621		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	570,915	14,760,735		5.00
7.00	00700	OPERATION OF PLANT	273,288	2,507,810		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	875,695		8.00
9.00	00900	HOUSEKEEPING	0	855,067		9.00
10.00	01000	DIETARY	0	239,157		10.00
11.00	01100	CAFETERIA	-285,627	352,331		11.00
13.00	01300	NURSING ADMINISTRATION	0	0		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	153,640		14.00
15.00	01500	PHARMACY	2,415	1,161,255		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	287,466	627,064		16.00
17.00	01700	SOCIAL SERVICE	-132	463,717		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-70,285	5,164,901		30.00
31.00	03100	INTENSIVE CARE UNIT	-2,607,286	4,281,335		31.00
43.00	04300	NURSERY	0	1,007,984		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,453,144	4,948,690		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,219,760		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-26,101	2,135,189		54.00
60.00	06000	LABORATORY	-12,000	2,734,272		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,316,410		65.00
66.00	06600	PHYSICAL THERAPY	-628,654	708,430		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,009,498		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	587,335		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,737,713		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-2,430,681	1,354,558		90.00
91.00	09100	EMERGENCY	-1,110,827	1,786,996		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,804,677	77,519,081		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	425,306		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,613,226		192.00
194.00	07950	OTHER DEPARTMENTS	0	0		194.00
194.01	07951	WOMEN'S RESOURCES	0	553,532		194.01
194.02	07952	MARKETING	0	1,190,159		194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	16,814		194.03
194.04	07954	CENTER FOR HEALING ARTS	0	155,843		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,804,677	83,473,961		200.00

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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - LEASEHOLD IMPROVEMENTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	469,714		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
	TOTALS		0	469,714		
	B - EQUIPMENT DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,137,098		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	TOTALS		0	2,137,098		
	C - INTEREST EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	324,449		1.00
2.00	REPRODUCTIVE MEDICINE	194.03	0	13,396		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	337,845		
	D - EQUIPMENT LEASES					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,151,167		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	TOTALS		0	1,151,167		
	E - BUILDING LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,799,607		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
	TOTALS		0	3,799,607		
	F - DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,737,713		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	1,737,713		

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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	G - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,596,833		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	195,454		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
	TOTALS		0	3,792,287		
	H - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	587,335		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	587,335		
	I - PROPERTY INSURANCE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	33,682		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	33,682		
	J - DIETARY					
1.00	DIETARY	10.00	144,815	0		1.00
2.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	257,532	0		2.00
3.00		0.00	0	0		3.00
4.00	DIETARY	10.00	0	94,342		4.00
5.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	167,774		5.00
6.00		0.00	0	0		6.00
	TOTALS		402,347	262,116		
	K - PROPERTY TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	123,823		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	130,991		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	254,814		
	L - LABOR & DELIVERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	3,099,213	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	120,547		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		3,099,213	120,547		
	M - ADVERTISING					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	502		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	502		
	N - EMERGENCY DEPARTMENT					
1.00	EMERGENCY	91.00	732,927	0		1.00
2.00		0.00	0	0		2.00
3.00	EMERGENCY	91.00	0	40,039		3.00
4.00		0.00	0	0		4.00
	TOTALS		732,927	40,039		
	O - INCENTIVE COMPENSATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	18,598	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	198,350	0		2.00
3.00	CAFETERIA	11.00	4,726	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	8,391	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	5,654	0		5.00
6.00	OPERATING ROOM	50.00	13,401	0		6.00
7.00	CLINIC	90.00	188,133	0		7.00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	469,702	0		8.00
9.00	MARKETING	194.02	23,916	0		9.00
10.00		0.00	0	0		10.00
	TOTALS		930,871	0		
	P - PHYSICIAN PART A					
1.00	ADULTS & PEDIATRICS	30.00	125,000	0		1.00
2.00		0.00	0	0		2.00
	TOTALS		125,000	0		
	Q - DISABILITY					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	18,095		1.00
2.00	OPERATION OF PLANT	7.00	0	6,162		2.00
3.00	HOUSEKEEPING	9.00	0	14,299		3.00

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
4.00	CAFETERIA	11.00	0	6,781	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,262	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,851	6.00
7.00	SOCIAL SERVICE	17.00	0	8,283	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	62,432	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	23,991	9.00
10.00	NURSERY	43.00	0	8,380	10.00
11.00	OPERATING ROOM	50.00	0	34,197	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,595	12.00
13.00	RESPIRATORY THERAPY	65.00	0	3,456	13.00
14.00	CLINIC	90.00	0	13,294	14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,146	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
	TOTALS		0	215,224	
	R - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	875,695	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	875,695	
500.00	Grand Total: Increases		5,290,358	15,815,385	500.00

RECLASSIFICATIONS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/22/2019 8:09 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LEASEHOLD IMPROVEMENTS						
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	403,387	9		2.00
3.00	OPERATION OF PLANT	7.00	0	4,578	9		3.00
4.00	CAFETERIA	11.00	0	4,006	9		4.00
5.00	PHARMACY	15.00	0	6,420	9		5.00
6.00	SOCIAL SERVICE	17.00	0	270	9		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	233	9		7.00
8.00	OPERATING ROOM	50.00	0	4,752	9		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	23,583	9		9.00
10.00	PHYSICAL THERAPY	66.00	0	816	9		10.00
11.00	CLINIC	90.00	0	21,128	9		11.00
12.00	WOMEN'S RESOURCES	194.01	0	541	9		12.00
	TOTALS		0	469,714			
	B - EQUIPMENT DEPRECIATION						
1.00		0.00	0	0	9		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	254	9		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	1,062,892	9		3.00
4.00	OPERATION OF PLANT	7.00	0	27,875	9		4.00
5.00	HOUSEKEEPING	9.00	0	6,503	9		5.00
6.00	CAFETERIA	11.00	0	5,895	9		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	6,552	9		7.00
8.00	PHARMACY	15.00	0	908	9		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,283	9		9.00
10.00	SOCIAL SERVICE	17.00	0	527	9		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	205,470	9		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	152,091	9		12.00
13.00	NURSERY	43.00	0	10,953	9		13.00
14.00	OPERATING ROOM	50.00	0	111,171	9		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	438,425	9		15.00
16.00	LABORATORY	60.00	0	1,203	9		16.00
17.00	RESPIRATORY THERAPY	65.00	0	31,354	9		17.00
18.00	PHYSICAL THERAPY	66.00	0	3,605	9		18.00
19.00	CLINIC	90.00	0	29,962	9		19.00
20.00	EMERGENCY	91.00	0	839	9		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	39,088	9		21.00
22.00	WOMEN'S RESOURCES	194.01	0	248	9		22.00
	TOTALS		0	2,137,098			
	C - INTEREST EXPENSE						
1.00		0.00	0	0	11		1.00
2.00		0.00	0	0	11		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	337,845	11		3.00
	TOTALS		0	337,845			
	D - EQUIPMENT LEASES						
1.00		0.00	0	0	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	332,104	10		2.00
3.00	OPERATION OF PLANT	7.00	0	1,006	10		3.00
4.00	PHARMACY	15.00	0	61,512	10		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	15,171	10		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	4,974	10		6.00
7.00	NURSERY	43.00	0	14,926	10		7.00
8.00	OPERATING ROOM	50.00	0	347,292	10		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	131,690	10		9.00
10.00	RESPIRATORY THERAPY	65.00	0	73,286	10		10.00
11.00	CLINIC	90.00	0	156,121	10		11.00
12.00	EMERGENCY	91.00	0	2,984	10		12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,990	10		13.00
14.00	WOMEN'S RESOURCES	194.01	0	8,111	10		14.00
	TOTALS		0	1,151,167			
	E - BUILDING LEASES						
1.00		0.00	0	0	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,376,749	10		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	3,871	10		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	116,192	10		4.00
5.00	PHYSICAL THERAPY	66.00	0	51,230	10		5.00
6.00	CLINIC	90.00	0	143,270	10		6.00
7.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	85,718	10		7.00
8.00	CENTER FOR HEALING ARTS	194.04	0	22,577	10		8.00
	TOTALS		0	3,799,607			
	F - DRUGS/IV SOLUTIONS						
1.00		0.00	0	0	0		1.00
2.00	PHARMACY	15.00	0	1,737,713	0		2.00
	TOTALS		0	1,737,713			

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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	G - MEDICAL SUPPLIES						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	382,618	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	142,061	0		4.00
5.00	NURSERY	43.00	0	119,046	0		5.00
6.00	OPERATING ROOM	50.00	0	2,901,441	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	135,465	0		7.00
8.00	LABORATORY	60.00	0	72	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	105,171	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	232	0		10.00
11.00	CLINIC	90.00	0	6,181	0		11.00
	TOTALS		0	3,792,287			
	H - IMPLANTABLE DEVICES						
1.00		0.00	0	0	0		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	587,335	0		2.00
	TOTALS		0	587,335			
	I - PROPERTY INSURANCE						
1.00		0.00	0	0	12		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	33,682	12		2.00
	TOTALS		0	33,682			
	J - DIETARY						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	CAFETERIA	11.00	402,347	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00	CAFETERIA	11.00	0	262,116	0		6.00
	TOTALS		402,347	262,116			
	K - PROPERTY TAXES						
1.00		0.00	0	0	13		1.00
2.00		0.00	0	0	13		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	254,814	13		3.00
	TOTALS		0	254,814			
	L - LABOR & DELIVERY						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	3,099,213	0	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	120,547	0		4.00
	TOTALS		3,099,213	120,547			
	M - ADVERTISING						
1.00		0.00	0	0	0		1.00
2.00	MARKETING	194.02	0	502	0		2.00
	TOTALS		0	502			
	N - EMERGENCY DEPARTMENT						
1.00		0.00	0	0	0		1.00
2.00	OPERATING ROOM	50.00	732,927	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00	OPERATING ROOM	50.00	0	40,039	0		4.00
	TOTALS		732,927	40,039			
	O - INCENTIVE COMPENSATION						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00	ADMINISTRATIVE & GENERAL	5.00	930,871	0	0		10.00
	TOTALS		930,871	0			
	P - PHYSICIAN PART A						
1.00		0.00	0	0	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	125,000	0	0		2.00
	TOTALS		125,000	0			
	Q - DISABILITY						
1.00		0.00	0	0	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

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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00	ADMINISTRATIVE & GENERAL	5.00	18,095	0	0		16.00
17.00	OPERATION OF PLANT	7.00	6,162	0	0		17.00
18.00	HOUSEKEEPING	9.00	14,299	0	0		18.00
19.00	CAFETERIA	11.00	6,781	0	0		19.00
20.00	CENTRAL SERVICES & SUPPLY	14.00	1,262	0	0		20.00
21.00	MEDICAL RECORDS & LIBRARY	16.00	1,851	0	0		21.00
22.00	SOCIAL SERVICE	17.00	8,283	0	0		22.00
23.00	ADULTS & PEDIATRICS	30.00	62,432	0	0		23.00
24.00	INTENSIVE CARE UNIT	31.00	23,991	0	0		24.00
25.00	NURSERY	43.00	8,380	0	0		25.00
26.00	OPERATING ROOM	50.00	34,197	0	0		26.00
27.00	RADIOLOGY-DIAGNOSTIC	54.00	3,595	0	0		27.00
28.00	RESPIRATORY THERAPY	65.00	3,456	0	0		28.00
29.00	CLINIC	90.00	13,294	0	0		29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	9,146	0	0		30.00
	TOTALS		215,224	0			
	R - LAUNDRY						
1.00		0.00	0	0	0		1.00
2.00	HOUSEKEEPING	9.00	0	875,695	0		2.00
	TOTALS		0	875,695			
500.00	Grand Total: Decreases		5,505,582	15,600,161			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/22/2019 8:09 am

		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	0	0	0	0	0	3.00
4.00	Building Improvements	4,103,199	758,361	0	758,361	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	17,774,008	1,840,115	0	1,840,115	361,037	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	21,877,207	2,598,476	0	2,598,476	361,037	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	21,877,207	2,598,476	0	2,598,476	361,037	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	0	0	3.00
4.00	Building Improvements	4,861,560	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	19,253,086	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,114,646	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	24,114,646	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/22/2019 8:09 am

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/22/2019 8:09 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	4,861,560	0	4,861,560	0.201602	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	19,253,086	0	19,253,086	0.798398	0	2.00
3.00	Total (sum of lines 1-2)	24,114,646	0	24,114,646	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	469,714	3,799,607	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,137,098	1,151,167	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,606,812	4,950,774	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	-87,613	0	123,823	0	4,305,531	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	324,449	33,682	130,991	0	3,777,387	2.00
3.00	Total (sum of lines 1-2)	236,836	33,682	254,814	0	8,082,918	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/22/2019 8:09 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-87,613	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-439	ADMINISTRATIVE & GENERAL	5.00	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	-8,713,356			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	9,107,730			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-226,912	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		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	B	-1,656	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	COFFEE SHOP REVENUE	B	-57,059	CAFETERIA	11.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/22/2019 8:09 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	CLASS REVENUE	B	-24,722	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	FITNESS CENTER REVENUE	B	-21,688	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
36.00	AHA DUES	A	-4,401	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	IHA DUES	A	-1,898	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PHYSICIAN RECRUITMENT	A	-210,964	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	LOBBYING	A	-240	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	HAF	A	-4,237,632	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	PHYSICIAN BILLING	A	-323,827	ADMINISTRATIVE & GENERAL	5.00	0	41.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,804,677				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: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/22/2019 8:09 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	FACILITY RENT	3,932,295	3,932,295	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	VARIOUS	3,863,812	68,535	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	VARIOUS	6,297,805	919,867	3.00
4.00	7.00	OPERATION OF PLANT	VARIOUS	1,394,757	1,121,469	4.00
4.01	14.00	CENTRAL SERVICES & SUPPLY	VARIOUS	4,563	4,563	4.01
4.02	15.00	PHARMACY	VARIOUS	1,034,958	1,032,543	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	VARIOUS	352,245	64,779	4.03
4.04	31.00	INTENSIVE CARE UNIT	VARIOUS	2,366	2,366	4.04
4.05	54.00	RADIOLOGY-DIAGNOSTIC	VARIOUS	7,431	7,431	4.05
4.06	60.00	LABORATORY	VARIOUS	9,872	9,872	4.06
4.07	66.00	PHYSICAL THERAPY	VARIOUS	1,421	1,421	4.07
4.08	90.00	CLINIC	VARIOUS	3,857	3,857	4.08
4.09	66.00	PHYSICAL THERAPY	THERAPY SERVICES	690,624	1,319,278	4.09
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			17,596,006	8,488,276	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:					

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

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

6.00	B	THE WOMEN'S HOS	50.00	DEACONESS HOSPI	50.00	6.00
7.00	A	DEACONESS HOSPI	51.00	PROGRESSIVE HEA	49.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0149	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/22/2019 8:09 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	10		1.00
2.00	3,795,277	0		2.00
3.00	5,377,938	0		3.00
4.00	273,288	0		4.00
4.01	0	0		4.01
4.02	2,415	0		4.02
4.03	287,466	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	-628,654	0		4.09
5.00	9,107,730			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	HOSPITAL		6.00
7.00	THERAPY SERVICE		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: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/22/2019 8:09 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	5,950	0	5,950	211,500	30	1.00
2.00	17.00	AGGREGATE-SOCIAL SERVICE	1,500	0	1,500	237,100	12	2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	125,000	0	125,000	237,100	480	3.00
4.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	2,622,286	2,607,286	15,000	237,100	180	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	3,265,435	1,894,135	1,371,300	246,400	6,857	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	51,200	3,200	48,000	271,900	192	6.00
7.00	60.00	AGGREGATE-LABORATORY	12,000	12,000	0	260,300	0	7.00
8.00	90.00	AGGREGATE-CLINIC	2,454,723	2,354,723	100,000	237,100	180	8.00
9.00	91.00	AGGREGATE-EMERGENCY	2,111,399	839,703	1,271,696	211,500	8,699	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			10,649,493	7,711,047	2,938,446		16,630	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	3,050	153	0	0	0	1.00
2.00	17.00	AGGREGATE-SOCIAL SERVICE	1,368	68	0	0	0	2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	54,715	2,736	0	0	0	3.00
4.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	20,518	1,026	0	0	41,093	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	812,291	40,615	0	0	0	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	25,099	1,255	0	0	0	6.00
7.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	7.00
8.00	90.00	AGGREGATE-CLINIC	20,518	1,026	0	0	86,496	8.00
9.00	91.00	AGGREGATE-EMERGENCY	884,538	44,227	0	0	192,652	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,822,097	91,106	0	0	320,241	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	3,050	2,900	2,900		1.00
2.00	17.00	AGGREGATE-SOCIAL SERVICE	0	1,368	132	132		2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	54,715	70,285	70,285		3.00
4.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	235	20,753	0	2,607,286		4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	812,291	559,009	2,453,144		5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	25,099	22,901	26,101		6.00
7.00	60.00	AGGREGATE-LABORATORY	0	0	0	12,000		7.00
8.00	90.00	AGGREGATE-CLINIC	3,524	24,042	75,958	2,430,681		8.00
9.00	91.00	AGGREGATE-EMERGENCY	116,034	1,000,572	271,124	1,110,827		9.00
10.00	0.00		0	0	0	0		10.00
200.00			119,793	1,941,890	1,002,309	8,713,356		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/22/2019 8:09 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,305,531	4,305,531				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,777,387		3,777,387			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,446,621	78,627	292	13,525,540		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,760,735	637,690	1,602,502	1,751,881	18,752,808	5.00
7.00	00700	OPERATION OF PLANT	2,507,810	138,311	33,177	264,177	2,943,475	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	875,695	0	0	0	875,695	8.00
9.00	00900	HOUSEKEEPING	855,067	23,534	7,470	220,454	1,106,525	9.00
10.00	01000	DIETARY	239,157	37,777	1,243	51,450	329,627	10.00
11.00	01100	CAFETERIA	352,331	100,715	3,316	137,243	593,605	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	153,640	28,053	7,527	37,156	226,376	14.00
15.00	01500	PHARMACY	1,161,255	32,354	71,705	0	1,265,314	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	627,064	17,858	1,474	88,655	735,051	16.00
17.00	01700	SOCIAL SERVICE	463,717	4,230	605	156,461	625,013	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,164,901	904,406	142,615	1,779,857	7,991,779	30.00
31.00	03100	INTENSIVE CARE UNIT	4,281,335	227,277	180,428	1,940,037	6,629,077	31.00
43.00	04300	NURSERY	1,007,984	123,272	29,728	344,898	1,505,882	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,948,690	517,961	515,679	1,171,433	7,153,763	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,219,760	462,615	110,846	1,101,085	4,894,306	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,135,189	203,345	654,918	567,154	3,560,606	54.00
60.00	06000	LABORATORY	2,734,272	5,965	1,382	0	2,741,619	60.00
65.00	06500	RESPIRATORY THERAPY	1,316,410	11,279	120,205	411,831	1,859,725	65.00
66.00	06600	PHYSICAL THERAPY	708,430	84,953	4,141	0	797,524	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,009,498	0	0	0	3,009,498	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	587,335	0	0	0	587,335	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,737,713	0	0	0	1,737,713	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,354,558	225,035	213,762	1,127,399	2,920,754	90.00
91.00	09100	EMERGENCY	1,786,996	88,315	15,373	873,230	2,763,914	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,519,081	3,953,572	3,718,388	12,024,401	75,606,984	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	425,306	67,167	2,211	91,496	586,180	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,613,226	126,526	47,187	1,144,379	4,931,318	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	553,532	125,261	9,601	105,121	793,515	194.01
194.02	07952	MARKETING	1,190,159	0	0	112,305	1,302,464	194.02
194.03	07953	REPRODUCTIVE MEDICINE	16,814	0	0	0	16,814	194.03
194.04	07954	CENTER FOR HEALING ARTS	155,843	33,005	0	47,838	236,686	194.04
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)	83,473,961	4,305,531	3,777,387	13,525,540	83,473,961	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/22/2019 8:09 am

		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	18,752,808					5.00
7.00	00700	OPERATION OF PLANT	852,866	3,796,341				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	253,731	0	1,129,426			8.00
9.00	00900	HOUSEKEEPING	320,613	25,890	0	1,453,028		9.00
10.00	01000	DIETARY	95,509	41,559	0	16,016	482,711	10.00
11.00	01100	CAFETERIA	171,996	110,796	0	42,698	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	65,592	30,861	0	11,893	0	14.00
15.00	01500	PHARMACY	366,622	35,593	0	13,717	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	212,980	19,646	0	7,571	0	16.00
17.00	01700	SOCIAL SERVICE	181,096	4,653	0	1,793	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,315,585	994,938	126,516	383,421	479,214	30.00
31.00	03100	INTENSIVE CARE UNIT	1,920,762	250,027	206,403	96,354	0	31.00
43.00	04300	NURSERY	436,326	135,612	76,334	52,261	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,072,789	569,809	519,727	219,589	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,418,115	508,923	127,172	196,125	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,031,678	223,700	0	86,208	0	54.00
60.00	06000	LABORATORY	794,379	6,562	0	2,529	0	60.00
65.00	06500	RESPIRATORY THERAPY	538,852	12,408	0	4,782	0	65.00
66.00	06600	PHYSICAL THERAPY	231,081	93,457	0	36,016	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	871,996	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	170,179	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	503,499	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	846,283	247,562	0	95,403	3,497	90.00
91.00	09100	EMERGENCY	800,839	97,155	73,274	37,441	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,473,368	3,409,151	1,129,426	1,303,817	482,711	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	169,844	73,891	0	28,475	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,428,840	139,191	0	53,640	0	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	229,919	137,799	0	53,104	0	194.01
194.02	07952	MARKETING	377,386	0	0	0	0	194.02
194.03	07953	REPRODUCTIVE MEDICINE	4,872	0	0	0	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	68,579	36,309	0	13,992	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,752,808	3,796,341	1,129,426	1,453,028	482,711	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/22/2019 8:09 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	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	919,095					11.00
13.00	01300	NURSING ADMINISTRATION	0	0				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,951	0	340,673			14.00
15.00	01500	PHARMACY	0	0	7,009	1,688,255		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,759	0	0	0	990,007	16.00
17.00	01700	SOCIAL SERVICE	18,568	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	182,343	0	10,500	269	71,271	30.00
31.00	03100	INTENSIVE CARE UNIT	148,779	0	13,198	1,932	95,341	31.00
43.00	04300	NURSERY	45,943	0	1,385	1,369	35,260	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	105,216	0	20,468	1	239,994	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	113,786	0	0	0	59,842	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	63,558	0	1,484	9,646	131,849	54.00
60.00	06000	LABORATORY	0	0	0	0	118,139	60.00
65.00	06500	RESPIRATORY THERAPY	40,468	0	5,438	0	21,151	65.00
66.00	06600	PHYSICAL THERAPY	0	0	699	18	16,079	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	232,389	0	52,295	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	44,821	0	7,193	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,646,411	76,229	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	48,323	0	806	9,982	32,110	90.00
91.00	09100	EMERGENCY	36,659	0	0	0	33,254	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	824,353	0	338,197	1,669,628	990,007	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,663	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	52,846	0	2,106	15,104	0	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	16,425	0	30	0	0	194.01
194.02	07952	MARKETING	8,808	0	4	0	0	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	0	3,523	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	0	0	336	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	919,095	0	340,673	1,688,255	990,007	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/22/2019 8:09 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	831,123					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	337,116	12,892,952	0	12,892,952		30.00
31.00	03100	INTENSIVE CARE UNIT	269,263	9,631,136	0	9,631,136		31.00
43.00	04300	NURSERY	224,744	2,515,116	0	2,515,116		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,901,356	0	10,901,356		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,318,269	0	7,318,269		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,108,729	0	5,108,729		54.00
60.00	06000	LABORATORY	0	3,663,228	0	3,663,228		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,482,824	0	2,482,824		65.00
66.00	06600	PHYSICAL THERAPY	0	1,174,874	0	1,174,874		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,166,178	0	4,166,178		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	809,528	0	809,528		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,963,852	0	3,963,852		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,204,720	0	4,204,720		90.00
91.00	09100	EMERGENCY	0	3,842,536	0	3,842,536		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	831,123	72,675,298	0	72,675,298		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	875,053	0	875,053		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,623,045	0	6,623,045		192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0		194.00
194.01	07951	WOMEN'S RESOURCES	0	1,230,792	0	1,230,792		194.01
194.02	07952	MARKETING	0	1,688,662	0	1,688,662		194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	25,209	0	25,209		194.03
194.04	07954	CENTER FOR HEALING ARTS	0	355,902	0	355,902		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	831,123	83,473,961	0	83,473,961		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/22/2019 8:09 am

		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	78,627	292	78,919	78,919	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	637,690	1,602,502	2,240,192	10,222	5.00
7.00	00700	OPERATION OF PLANT	0	138,311	33,177	171,488	1,541	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	23,534	7,470	31,004	1,286	9.00
10.00	01000	DIETARY	0	37,777	1,243	39,020	300	10.00
11.00	01100	CAFETERIA	0	100,715	3,316	104,031	801	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,053	7,527	35,580	217	14.00
15.00	01500	PHARMACY	0	32,354	71,705	104,059	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,858	1,474	19,332	517	16.00
17.00	01700	SOCIAL SERVICE	0	4,230	605	4,835	913	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	904,406	142,615	1,047,021	10,385	30.00
31.00	03100	INTENSIVE CARE UNIT	0	227,277	180,428	407,705	11,322	31.00
43.00	04300	NURSERY	0	123,272	29,728	153,000	2,012	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	517,961	515,679	1,033,640	6,835	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	462,615	110,846	573,461	6,425	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	203,345	654,918	858,263	3,309	54.00
60.00	06000	LABORATORY	0	5,965	1,382	7,347	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,279	120,205	131,484	2,403	65.00
66.00	06600	PHYSICAL THERAPY	0	84,953	4,141	89,094	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	225,035	213,762	438,797	6,578	90.00
91.00	09100	EMERGENCY	0	88,315	15,373	103,688	5,095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,953,572	3,718,388	7,671,960	70,161	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	67,167	2,211	69,378	534	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	126,526	47,187	173,713	6,677	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	0	125,261	9,601	134,862	613	194.01
194.02	07952	MARKETING	0	0	0	0	655	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	0	0	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	0	33,005	0	33,005	279	194.04
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	4,305,531	3,777,387	8,082,918	78,919	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/22/2019 8:09 am

		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	2,250,414					5.00
7.00	00700	OPERATION OF PLANT	102,348	275,377				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,449	0	30,449			8.00
9.00	00900	HOUSEKEEPING	38,475	1,878	0	72,643		9.00
10.00	01000	DIETARY	11,461	3,015	0	801	54,597	10.00
11.00	01100	CAFETERIA	20,640	8,037	0	2,135	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,871	2,239	0	595	0	14.00
15.00	01500	PHARMACY	43,996	2,582	0	686	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,558	1,425	0	379	0	16.00
17.00	01700	SOCIAL SERVICE	21,732	338	0	90	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	277,878	72,168	3,413	19,165	54,201	30.00
31.00	03100	INTENSIVE CARE UNIT	230,500	18,136	5,568	4,817	0	31.00
43.00	04300	NURSERY	52,361	9,837	2,059	2,613	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	248,743	41,333	14,002	10,978	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	170,180	36,916	3,430	9,805	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	123,806	16,227	0	4,310	0	54.00
60.00	06000	LABORATORY	95,329	476	0	126	0	60.00
65.00	06500	RESPIRATORY THERAPY	64,664	900	0	239	0	65.00
66.00	06600	PHYSICAL THERAPY	27,731	6,779	0	1,801	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	104,643	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,422	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,422	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	101,558	17,957	0	4,770	396	90.00
91.00	09100	EMERGENCY	96,104	7,047	1,977	1,872	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,976,871	247,290	30,449	65,182	54,597	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,382	5,360	0	1,424	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	171,467	10,097	0	2,682	0	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	27,591	9,996	0	2,655	0	194.01
194.02	07952	MARKETING	45,288	0	0	0	0	194.02
194.03	07953	REPRODUCTIVE MEDICINE	585	0	0	0	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	8,230	2,634	0	700	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,250,414	275,377	30,449	72,643	54,597	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/22/2019 8:09 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	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	135,644					11.00
13.00	01300	NURSING ADMINISTRATION	0	0				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	878	0	47,380			14.00
15.00	01500	PHARMACY	0	0	975	152,298		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,178	0	0	0	49,389	16.00
17.00	01700	SOCIAL SERVICE	2,740	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,914	0	1,460	24	3,554	30.00
31.00	03100	INTENSIVE CARE UNIT	21,957	0	1,836	174	4,755	31.00
43.00	04300	NURSERY	6,780	0	193	123	1,758	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,528	0	2,847	0	11,985	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,793	0	0	0	2,984	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,380	0	206	870	6,576	54.00
60.00	06000	LABORATORY	0	0	0	0	5,892	60.00
65.00	06500	RESPIRATORY THERAPY	5,972	0	756	0	1,055	65.00
66.00	06600	PHYSICAL THERAPY	0	0	97	2	802	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	32,320	0	2,608	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	6,233	0	359	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	148,524	3,802	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,132	0	112	900	1,601	90.00
91.00	09100	EMERGENCY	5,410	0	0	0	1,658	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	121,662	0	47,035	150,617	49,389	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,459	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,799	0	293	1,363	0	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	2,424	0	4	0	0	194.01
194.02	07952	MARKETING	1,300	0	1	0	0	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	0	318	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	0	0	47	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	135,644	0	47,380	152,298	49,389	202.00

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		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	30,648					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,431	1,528,614	0	1,528,614		30.00
31.00	03100	INTENSIVE CARE UNIT	9,929	716,699	0	716,699		31.00
43.00	04300	NURSERY	8,288	239,024	0	239,024		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,385,891	0	1,385,891		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	819,994	0	819,994		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,022,947	0	1,022,947		54.00
60.00	06000	LABORATORY	0	109,170	0	109,170		60.00
65.00	06500	RESPIRATORY THERAPY	0	207,473	0	207,473		65.00
66.00	06600	PHYSICAL THERAPY	0	126,306	0	126,306		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	139,571	0	139,571		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,014	0	27,014		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	212,748	0	212,748		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	579,801	0	579,801		90.00
91.00	09100	EMERGENCY	0	222,851	0	222,851		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,648	7,338,103	0	7,338,103		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	99,537	0	99,537		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	374,091	0	374,091		192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0		194.00
194.01	07951	WOMEN'S RESOURCES	0	178,145	0	178,145		194.01
194.02	07952	MARKETING	0	47,244	0	47,244		194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	903	0	903		194.03
194.04	07954	CENTER FOR HEALING ARTS	0	44,895	0	44,895		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	30,648	8,082,918	0	8,082,918		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/22/2019 8:09 am

		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	119,101					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,288,263				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,175	254	38,070,221			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,640	1,394,996	4,931,002	-18,752,808	64,721,153	5.00
7.00	00700	OPERATION OF PLANT	3,826	28,881	743,577	0	2,943,475	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	875,695	8.00
9.00	00900	HOUSEKEEPING	651	6,503	620,510	0	1,106,525	9.00
10.00	01000	DIETARY	1,045	1,082	144,815	0	329,627	10.00
11.00	01100	CAFETERIA	2,786	2,887	386,297	0	593,605	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	776	6,552	104,582	0	226,376	14.00
15.00	01500	PHARMACY	895	62,420	0	0	1,265,314	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	494	1,283	249,535	0	735,051	16.00
17.00	01700	SOCIAL SERVICE	117	527	440,388	0	625,013	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,018	124,148	5,009,744	0	7,991,779	30.00
31.00	03100	INTENSIVE CARE UNIT	6,287	157,065	5,460,628	0	6,629,077	31.00
43.00	04300	NURSERY	3,410	25,879	970,781	0	1,505,882	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,328	448,905	3,297,221	0	7,153,763	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,797	96,493	3,099,213	0	4,894,306	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,625	570,115	1,596,363	0	3,560,606	54.00
60.00	06000	LABORATORY	165	1,203	0	0	2,741,619	60.00
65.00	06500	RESPIRATORY THERAPY	312	104,640	1,159,176	0	1,859,725	65.00
66.00	06600	PHYSICAL THERAPY	2,350	3,605	0	0	797,524	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,009,498	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	587,335	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,737,713	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,225	186,083	3,173,279	0	2,920,754	90.00
91.00	09100	EMERGENCY	2,443	13,382	2,457,872	0	2,763,914	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	109,365	3,236,903	33,844,983	-18,752,808	56,854,176	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,858	1,925	257,532	0	586,180	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,500	41,077	3,221,071	0	4,931,318	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	3,465	8,358	295,882	0	793,515	194.01
194.02	07952	MARKETING	0	0	316,104	0	1,302,464	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	0	0	16,814	194.03
194.04	07954	CENTER FOR HEALING ARTS	913	0	134,649	0	236,686	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,305,531	3,777,387	13,525,540		18,752,808	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.150251	1.148748	0.355279		0.289748	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			78,919		2,250,414	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002073		0.034771	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

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		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS REVENUE)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			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	95,460					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	83,928,194				8.00
9.00	00900	HOUSEKEEPING	651	0	94,809			9.00
10.00	01000	DIETARY	1,045	0	1,045	28,572		10.00
11.00	01100	CAFETERIA	2,786	0	2,786	0	3,861	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	776	0	776	0	25	14.00
15.00	01500	PHARMACY	895	0	895	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	494	0	494	0	62	16.00
17.00	01700	SOCIAL SERVICE	117	0	117	0	78	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,018	9,401,475	25,018	28,365	766	30.00
31.00	03100	INTENSIVE CARE UNIT	6,287	15,337,964	6,287	0	625	31.00
43.00	04300	NURSERY	3,410	5,672,449	3,410	0	193	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,328	38,621,039	14,328	0	442	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,797	9,450,230	12,797	0	478	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,625	0	5,625	0	267	54.00
60.00	06000	LABORATORY	165	0	165	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	312	0	312	0	170	65.00
66.00	06600	PHYSICAL THERAPY	2,350	0	2,350	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,225	0	6,225	207	203	90.00
91.00	09100	EMERGENCY	2,443	5,445,037	2,443	0	154	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,724	83,928,194	85,073	28,572	3,463	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,858	0	1,858	0	70	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,500	0	3,500	0	222	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	3,465	0	3,465	0	69	194.01
194.02	07952	MARKETING	0	0	0	0	37	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	0	0	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	913	0	913	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,796,341	1,129,426	1,453,028	482,711	919,095	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.768919	0.013457	15.325845	16.894547	238.045843	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	275,377	30,449	72,643	54,597	135,644	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.884737	0.000363	0.766204	1.910857	35.131831	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: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/22/2019 8:09 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		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	0					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,464,132				14.00
15.00	01500	PHARMACY	0	91,848	1,638,030			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5	0	159,279,567		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	22,403	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	137,594	261	11,465,664	9,087	30.00
31.00	03100	INTENSIVE CARE UNIT	0	172,952	1,875	15,337,964	7,258	31.00
43.00	04300	NURSERY	0	18,146	1,328	5,672,449	6,058	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	268,216	1	38,621,039	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	9,627,114	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,452	9,359	21,211,293	0	54.00
60.00	06000	LABORATORY	0	0	0	19,005,695	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	71,264	0	3,402,658	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,164	17	2,586,657	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,045,153	0	8,412,948	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	587,335	0	1,157,223	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,597,431	12,263,396	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	10,564	9,685	5,165,689	0	90.00
91.00	09100	EMERGENCY	0	0	0	5,349,778	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,431,693	1,619,957	159,279,567	22,403	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	27,596	14,655	0	0	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	0	388	0	0	0	194.01
194.02	07952	MARKETING	0	52	0	0	0	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	3,418	0	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	0	4,403	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	340,673	1,688,255	990,007	831,123	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.076313	1.030662	0.006216	37.098737	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	47,380	152,298	49,389	30,648	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.010613	0.092976	0.000310	1.368031	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: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/22/2019 8:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,892,952		12,892,952	70,285	12,963,237	30.00
31.00	03100	INTENSIVE CARE UNIT	9,631,136		9,631,136	0	9,631,136	31.00
43.00	04300	NURSERY	2,515,116		2,515,116	0	2,515,116	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,901,356		10,901,356	559,009	11,460,365	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,318,269		7,318,269	0	7,318,269	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,108,729		5,108,729	22,901	5,131,630	54.00
60.00	06000	LABORATORY	3,663,228		3,663,228	0	3,663,228	60.00
65.00	06500	RESPIRATORY THERAPY	2,482,824	0	2,482,824	0	2,482,824	65.00
66.00	06600	PHYSICAL THERAPY	1,174,874	0	1,174,874	0	1,174,874	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,166,178		4,166,178	0	4,166,178	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	809,528		809,528	0	809,528	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,963,852		3,963,852	0	3,963,852	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,204,720		4,204,720	75,958	4,280,678	90.00
91.00	09100	EMERGENCY	3,842,536		3,842,536	271,124	4,113,660	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,028,781		2,028,781		2,028,781	92.00
200.00		Subtotal (see instructions)	74,704,079	0	74,704,079	999,277	75,703,356	200.00
201.00		Less Observation Beds	2,028,781		2,028,781		2,028,781	201.00
202.00		Total (see instructions)	72,675,298	0	72,675,298	999,277	73,674,575	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/22/2019 8:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,401,475		9,401,475			30.00
31.00	03100	INTENSIVE CARE UNIT	15,337,964		15,337,964			31.00
43.00	04300	NURSERY	5,672,449		5,672,449			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,269,641	27,351,398	38,621,039	0.282265	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,450,230	176,884	9,627,114	0.760173	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,983,210	18,228,083	21,211,293	0.240849	0.000000	54.00
60.00	06000	LABORATORY	11,526,510	7,479,185	19,005,695	0.192744	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,392,600	10,058	3,402,658	0.729672	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	405,232	2,181,425	2,586,657	0.454206	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,510,078	5,902,870	8,412,948	0.495210	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,889	1,116,334	1,157,223	0.699544	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,080,702	3,182,694	12,263,396	0.323226	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	191,010	4,974,679	5,165,689	0.813971	0.000000	90.00
91.00	09100	EMERGENCY	1,136,202	4,213,576	5,349,778	0.718261	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,193,352	870,837	2,064,189	0.982847	0.000000	92.00
200.00		Subtotal (see instructions)	83,591,544	75,688,023	159,279,567			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	83,591,544	75,688,023	159,279,567			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/22/2019 8:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.296739		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.760173		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.241929		54.00
60.00	06000	LABORATORY	0.192744		60.00
65.00	06500	RESPIRATORY THERAPY	0.729672		65.00
66.00	06600	PHYSICAL THERAPY	0.454206		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.495210		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.699544		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323226		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.828675		90.00
91.00	09100	EMERGENCY	0.768940		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.982847		92.00
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: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,892,952		12,892,952	70,285	12,963,237	30.00
31.00	03100	INTENSIVE CARE UNIT	9,631,136		9,631,136	0	9,631,136	31.00
43.00	04300	NURSERY	2,515,116		2,515,116	0	2,515,116	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,901,356		10,901,356	559,009	11,460,365	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,318,269		7,318,269	0	7,318,269	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,108,729		5,108,729	22,901	5,131,630	54.00
60.00	06000	LABORATORY	3,663,228		3,663,228	0	3,663,228	60.00
65.00	06500	RESPIRATORY THERAPY	2,482,824	0	2,482,824	0	2,482,824	65.00
66.00	06600	PHYSICAL THERAPY	1,174,874	0	1,174,874	0	1,174,874	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,166,178		4,166,178	0	4,166,178	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	809,528		809,528	0	809,528	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,963,852		3,963,852	0	3,963,852	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,204,720		4,204,720	75,958	4,280,678	90.00
91.00	09100	EMERGENCY	3,842,536		3,842,536	271,124	4,113,660	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,028,781		2,028,781		2,028,781	92.00
200.00		Subtotal (see instructions)	74,704,079	0	74,704,079	999,277	75,703,356	200.00
201.00		Less Observation Beds	2,028,781		2,028,781		2,028,781	201.00
202.00		Total (see instructions)	72,675,298	0	72,675,298	999,277	73,674,575	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | Hospital | PPS

		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	9,401,475		9,401,475			30.00
31.00	03100	INTENSIVE CARE UNIT	15,337,964		15,337,964			31.00
43.00	04300	NURSERY	5,672,449		5,672,449			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,269,641	27,351,398	38,621,039	0.282265	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,450,230	176,884	9,627,114	0.760173	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,983,210	18,228,083	21,211,293	0.240849	0.000000	54.00
60.00	06000	LABORATORY	11,526,510	7,479,185	19,005,695	0.192744	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,392,600	10,058	3,402,658	0.729672	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	405,232	2,181,425	2,586,657	0.454206	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,510,078	5,902,870	8,412,948	0.495210	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,889	1,116,334	1,157,223	0.699544	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,080,702	3,182,694	12,263,396	0.323226	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	191,010	4,974,679	5,165,689	0.813971	0.000000	90.00
91.00	09100	EMERGENCY	1,136,202	4,213,576	5,349,778	0.718261	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,193,352	870,837	2,064,189	0.982847	0.000000	92.00
200.00		Subtotal (see instructions)	83,591,544	75,688,023	159,279,567			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	83,591,544	75,688,023	159,279,567			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.296739		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.760173		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.241929		54.00
60.00	06000	LABORATORY	0.192744		60.00
65.00	06500	RESPIRATORY THERAPY	0.729672		65.00
66.00	06600	PHYSICAL THERAPY	0.454206		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.495210		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.699544		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323226		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.828675		90.00
91.00	09100	EMERGENCY	0.768940		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.982847		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part II | Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,901,356	1,385,891	9,515,465	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,318,269	819,994	6,498,275	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,108,729	1,022,947	4,085,782	0	0	54.00
60.00	06000	LABORATORY	3,663,228	109,170	3,554,058	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,482,824	207,473	2,275,351	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,174,874	126,306	1,048,568	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,166,178	139,571	4,026,607	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	809,528	27,014	782,514	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,963,852	212,748	3,751,104	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,204,720	579,801	3,624,919	0	0	90.00
91.00	09100	EMERGENCY	3,842,536	222,851	3,619,685	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,028,781	239,232	1,789,549	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	49,664,875	5,092,998	44,571,877	0	0	200.00
201.00		Less Observation Beds	2,028,781	239,232	1,789,549	0	0	201.00
202.00		Total (line 200 minus line 201)	47,636,094	4,853,766	42,782,328	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part II | Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	10,901,356	38,621,039	0.282265		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,318,269	9,627,114	0.760173		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,108,729	21,211,293	0.240849		54.00
60.00	06000	LABORATORY	3,663,228	19,005,695	0.192744		60.00
65.00	06500	RESPIRATORY THERAPY	2,482,824	3,402,658	0.729672		65.00
66.00	06600	PHYSICAL THERAPY	1,174,874	2,586,657	0.454206		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,166,178	8,412,948	0.495210		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	809,528	1,157,223	0.699544		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,963,852	12,263,396	0.323226		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	4,204,720	5,165,689	0.813971		90.00
91.00	09100	EMERGENCY	3,842,536	5,349,778	0.718261		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,028,781	2,064,189	0.982847		92.00
200.00		Subtotal (sum of lines 50 thru 199)	49,664,875	128,867,679			200.00
201.00		Less Observation Beds	2,028,781	0			201.00
202.00		Total (line 200 minus line 201)	47,636,094	128,867,679			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/22/2019 8:09 am

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	1,528,614	0	1,528,614	10,773	141.89	30.00
31.00	INTENSIVE CARE UNIT	716,699		716,699	7,258	98.75	31.00
43.00	NURSERY	239,024		239,024	6,058	39.46	43.00
200.00	Total (lines 30 through 199)	2,484,337		2,484,337	24,089		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	61	8,655				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	61	8,655				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/22/2019 8:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,385,891	38,621,039	0.035884	414,135	14,861	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	819,994	9,627,114	0.085175	25,768	2,195	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,022,947	21,211,293	0.048227	15,705	757	54.00
60.00	06000	LABORATORY	109,170	19,005,695	0.005744	164,143	943	60.00
65.00	06500	RESPIRATORY THERAPY	207,473	3,402,658	0.060974	25	2	65.00
66.00	06600	PHYSICAL THERAPY	126,306	2,586,657	0.048830	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	139,571	8,412,948	0.016590	112,725	1,870	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,014	1,157,223	0.023344	1,667	39	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	212,748	12,263,396	0.017348	68,844	1,194	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	579,801	5,165,689	0.112241	542	61	90.00
91.00	09100	EMERGENCY	222,851	5,349,778	0.041656	5,997	250	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	239,232	2,064,189	0.115896	7,917	918	92.00
200.00		Total (lines 50 through 199)	5,092,998	128,867,679		817,468	23,090	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/22/2019 8:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	10,773	0.00	61	30.00
31.00	03100	INTENSIVE CARE UNIT		0	7,258	0.00	0	31.00
43.00	04300	NURSERY		0	6,058	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	24,089		61	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/22/2019 8:09 am

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						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/22/2019 8:09 am

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						
50.00	05000	OPERATING ROOM	0	0	0	38,621,039	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	9,627,114	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,211,293	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	19,005,695	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,402,658	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,586,657	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,412,948	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,157,223	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,263,396	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,165,689	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,349,778	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,064,189	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	128,867,679		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/22/2019 8:09 am

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						
50.00	05000	OPERATING ROOM	0.000000	414,135	0	3,330,753	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	25,768	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	15,705	0	1,014,634	0	54.00
60.00	06000	LABORATORY	0.000000	164,143	0	679,092	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	25	0	953	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	4,125	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	112,725	0	782,414	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,667	0	226,740	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	68,844	0	322,170	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	542	0	18,913	0	90.00
91.00	09100	EMERGENCY	0.000000	5,997	0	50,635	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	7,917	0	6,468	0	92.00
200.00		Total (lines 50 through 199)		817,468	0	6,436,897	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/22/2019 8:09 am

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						
50.00	05000	OPERATING ROOM	0.282265	3,330,753	0	0	940,155	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.760173	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240849	1,014,634	0	0	244,374	54.00
60.00	06000	LABORATORY	0.192744	679,092	0	0	130,891	60.00
65.00	06500	RESPIRATORY THERAPY	0.729672	953	0	0	695	65.00
66.00	06600	PHYSICAL THERAPY	0.454206	4,125	0	0	1,874	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.495210	782,414	0	0	387,459	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.699544	226,740	0	0	158,615	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323226	322,170	0	0	104,134	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.813971	18,913	0	0	15,395	90.00
91.00	09100	EMERGENCY	0.718261	50,635	0	0	36,369	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.982847	6,468	0	0	6,357	92.00
200.00		Subtotal (see instructions)		6,436,897	0	0	2,026,318	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		6,436,897	0	0	2,026,318	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/22/2019 8:09 am

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				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | 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	1,528,614	0	1,528,614	10,773	141.89	30.00
31.00	INTENSIVE CARE UNIT	716,699		716,699	7,258	98.75	31.00
43.00	NURSERY	239,024		239,024	6,058	39.46	43.00
200.00	Total (lines 30 through 199)	2,484,337		2,484,337	24,089		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	351	49,803				30.00
31.00	INTENSIVE CARE UNIT	228	22,515				31.00
43.00	NURSERY	287	11,325				43.00
200.00	Total (lines 30 through 199)	866	83,643				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,385,891	38,621,039	0.035884	3,313,023	118,885	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	819,994	9,627,114	0.085175	3,166,944	269,744	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,022,947	21,211,293	0.048227	1,206,462	58,184	54.00
60.00	06000	LABORATORY	109,170	19,005,695	0.005744	5,090,019	29,237	60.00
65.00	06500	RESPIRATORY THERAPY	207,473	3,402,658	0.060974	1,469,554	89,605	65.00
66.00	06600	PHYSICAL THERAPY	126,306	2,586,657	0.048830	255,350	12,469	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	139,571	8,412,948	0.016590	736,538	12,219	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,014	1,157,223	0.023344	35,749	835	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	212,748	12,263,396	0.017348	3,602,310	62,493	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	579,801	5,165,689	0.112241	87,822	9,857	90.00
91.00	09100	EMERGENCY	222,851	5,349,778	0.041656	418,275	17,424	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	239,232	2,064,189	0.115896	22,097	2,561	92.00
200.00		Total (lines 50 through 199)	5,092,998	128,867,679		19,404,143	683,513	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	10,773	0.00	351	30.00
31.00	03100	INTENSIVE CARE UNIT		0	7,258	0.00	228	31.00
43.00	04300	NURSERY		0	6,058	0.00	287	43.00
200.00		Total (lines 30 through 199)		0	24,089		866	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | 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						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | 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						
50.00	05000	OPERATING ROOM	0	0	0	38,621,039	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	9,627,114	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,211,293	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	19,005,695	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,402,658	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,586,657	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,412,948	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,157,223	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,263,396	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,165,689	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,349,778	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,064,189	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	128,867,679		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | 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						
50.00	05000	OPERATING ROOM	0.000000	3,313,023	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	3,166,944	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,206,462	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	5,090,019	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,469,554	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	255,350	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	736,538	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	35,749	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,602,310	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	87,822	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	418,275	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	22,097	0	0	0	92.00
200.00		Total (lines 50 through 199)		19,404,143	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | 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						
50.00	05000	OPERATING ROOM	0.282265	0	0	4,658,168	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.760173	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240849	0	0	1,604,319	0	54.00
60.00	06000	LABORATORY	0.192744	0	0	2,084,202	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.729672	0	0	4,015	0	65.00
66.00	06600	PHYSICAL THERAPY	0.454206	0	0	1,228	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.495210	0	0	962,682	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.699544	0	0	40,920	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323226	0	0	645,847	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.813971	0	0	1,590,158	0	90.00
91.00	09100	EMERGENCY	0.718261	0	0	1,770,311	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.982847	0	0	350,657	0	92.00
200.00		Subtotal (see instructions)		0	0	13,712,507	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	0	13,712,507	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | 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				
50.00	05000	OPERATING ROOM	0	1,314,838		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	386,399		54.00
60.00	06000	LABORATORY	0	401,717		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,930		65.00
66.00	06600	PHYSICAL THERAPY	0	558		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	476,730		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,625		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	208,755		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	1,294,342		90.00
91.00	09100	EMERGENCY	0	1,271,545		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	344,642		92.00
200.00		Subtotal (see instructions)	0	5,731,081		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	5,731,081		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/22/2019 8:09 am

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)	10,773	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,773	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	9,087	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)	61	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)	12,963,237	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)	12,963,237	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)	12,963,237	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)	1,203.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	73,402	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)	73,402	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/22/2019 8:09 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,631,136	7,258	1,326.97	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	270,015	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	343,417	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)	8,655	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	23,090	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	31,745	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	311,672	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,686	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,203.31	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,028,781	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/22/2019 8:09 am

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	1,528,614	12,963,237	0.117919	2,028,781	239,232	90.00
91.00	Nursing School cost	0	12,963,237	0.000000	2,028,781	0	91.00
92.00	Allied health cost	0	12,963,237	0.000000	2,028,781	0	92.00
93.00	All other Medical Education	0	12,963,237	0.000000	2,028,781	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | 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)	10,773	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,773	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	9,087	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)	351	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)	6,058	15.00
16.00	Nursery days (title V or XIX only)	287	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)	12,963,237	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)	12,963,237	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)	12,963,237	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)	1,203.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	422,362	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)	422,362	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | 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)	2,515,116	6,058	415.17	287	119,154	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,631,136	7,258	1,326.97	228	302,549	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	7,821,982	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,666,047	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)	83,643	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	683,513	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	767,156	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,898,891	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,686	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,203.31	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,028,781	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | 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	1,528,614	12,963,237	0.117919	2,028,781	239,232	90.00
91.00	Nursing School cost	0	12,963,237	0.000000	2,028,781	0	91.00
92.00	Allied health cost	0	12,963,237	0.000000	2,028,781	0	92.00
93.00	All other Medical Education	0	12,963,237	0.000000	2,028,781	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/22/2019 8:09 am

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		58,814		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.296739	414,135	122,890	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.760173	25,768	19,588	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.241929	15,705	3,799	54.00
60.00	06000	LABORATORY	0.192744	164,143	31,638	60.00
65.00	06500	RESPIRATORY THERAPY	0.729672	25	18	65.00
66.00	06600	PHYSICAL THERAPY	0.454206	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.495210	112,725	55,823	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.699544	1,667	1,166	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323226	68,844	22,252	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.828675	542	449	90.00
91.00	09100	EMERGENCY	0.768940	5,997	4,611	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.982847	7,917	7,781	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		817,468	270,015	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)		817,468		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/22/2019 8:09 am

Title XIX | 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		3,031,552		30.00
31.00	03100	INTENSIVE CARE UNIT		7,106,178		31.00
43.00	04300	NURSERY		1,640,514		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.296739	3,313,023	983,103	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.760173	3,166,944	2,407,425	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.241929	1,206,462	291,878	54.00
60.00	06000	LABORATORY	0.192744	5,090,019	981,071	60.00
65.00	06500	RESPIRATORY THERAPY	0.729672	1,469,554	1,072,292	65.00
66.00	06600	PHYSICAL THERAPY	0.454206	255,350	115,982	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.495210	736,538	364,741	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.699544	35,749	25,008	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323226	3,602,310	1,164,360	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.828675	87,822	72,776	90.00
91.00	09100	EMERGENCY	0.768940	418,275	321,628	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.982847	22,097	21,718	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		19,404,143	7,821,982	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)		19,404,143		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0149	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/22/2019 8:09 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	177,200	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	83,897	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	0	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	69.38	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	17.72	30.00
31.00	Percentage of Medicaid patient days (see instructions)	52.04	31.00
32.00	Sum of lines 30 and 31	69.76	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	7,833	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0149	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/22/2019 8:09 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,232,525	920,777	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	921,861	232,086	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,153,947		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	1,422,877		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	1,422,877	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	21,248	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	1,444,125	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	1,444,125	61.00
62.00	Deductibles billed to program beneficiaries	44,220	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	10,672	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	6,937	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,672	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	1,406,842	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	1,569	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Date/Time Prepared: 5/22/2019 8:09 am

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		1,408,411	71.00
71.01	Sequestration adjustment (see instructions)		28,168	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		1,353,369	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		26,874	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		74,817	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/22/2019 8:09 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	177,200	0	177,200		177,200	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	83,897	0		83,897	83,897	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	7,833	0	5,316	2,517	7,833	11.00
11.01	Uncompensated care payments	36.00	1,153,947	0	921,861	232,086	1,153,947	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,422,877	0	1,104,377	318,500	1,422,877	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,422,877	0	1,104,377	318,500	1,422,877	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	21,248	0	14,322	6,926	21,248	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/22/2019 8:09 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,118,699	325,426	1,444,125	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	21,248	0	14,322	6,926	21,248	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	21,248	0	14,322	6,926	21,248	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.250000	0.250000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			279,675		279,675	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				81,357	81,357	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/22/2019 8:09 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	177,200	177,200		177,200	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	83,897		83,897	83,897	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	7,833	5,316	2,517	7,833	11.00
11.01	Uncompensated care payments	36.00	1,153,947	921,861	232,086	1,153,947	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,422,877	1,104,377	318,500	1,422,877	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,422,877	1,104,377	318,500	1,422,877	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	21,248	14,322	6,926	21,248	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			1,118,699	325,426	1,444,125	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/22/2019 8:09 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	21,248	14,322	6,926	21,248	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	21,248	14,322	6,926	21,248	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	1,569	964	605	1,569	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0149	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/22/2019 8:09 am
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,026,318	2.00
3.00	OPPS payments	1,651,812	3.00
4.00	Outlier payment (see instructions)	14,718	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)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	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)	0	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)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	1,666,530	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)	294,833	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)	1,371,697	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)	1,371,697	30.00
31.00	Primary payer payments	77	31.00
32.00	Subtotal (line 30 minus line 31)	1,371,620	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)	30,136	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	19,588	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	24,892	36.00
37.00	Subtotal (see instructions)	1,391,208	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)	1,391,208	40.00
40.01	Sequestration adjustment (see instructions)	27,824	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,344,182	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	19,202	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	10,000	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: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/22/2019 8:09 am

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		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		1,353,369		1,344,182	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)		1,353,369		1,344,182	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		26,874		19,202	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,380,243		1,363,384	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0149	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/22/2019 8:09 am
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		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/22/2019 8:09 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	0	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	29,014,850	0	0	0	4.00
5.00	Other receivable	1,448,130	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,025,720	0	0	0	6.00
7.00	Inventory	604,087	0	0	0	7.00
8.00	Prepaid expenses	1,299,957	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,341,304	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	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	4,863,576	0	0	0	17.00
18.00	Accumulated depreciation	-1,690,119	0	0	0	18.00
19.00	Fixed equipment	1,186,917	0	0	0	19.00
20.00	Accumulated depreciation	-1,186,917	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	0	0	0	0	24.00
25.00	Minor equipment depreciable	18,066,169	0	0	0	25.00
26.00	Accumulated depreciation	-12,340,166	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	8,899,460	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	5,224,479	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,224,479	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	32,465,243	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,974,643	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,563,683	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,256,183	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	55,168	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,849,677	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,945,634	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)	6,945,634	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,795,311	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	9,669,932				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)	9,669,932	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	32,465,243	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/22/2019 8:09 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		8,932,307		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		14,471,236				2.00
3.00	Total (sum of line 1 and line 2)		23,403,543		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)		23,403,543		0		11.00
12.00	DISTRIBUTION TO MEMBERS	13,733,557		0		0	12.00
13.00	ROUNDING	54		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)		13,733,611		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,669,932		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	DISTRIBUTION TO MEMBERS		0		12.00
13.00	ROUNDING		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: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/22/2019 8:09 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	15,077,654		15,077,654	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)	15,077,654		15,077,654	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	20,874,711		20,874,711	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)	20,874,711		20,874,711	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	35,952,365		35,952,365	17.00
18.00	Ancillary services	51,760,187	73,867,594	125,627,781	18.00
19.00	Outpatient services	1,417,619	16,488,679	17,906,298	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON-REIMBURSABLE	0	4,030,452	4,030,452	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	89,130,171	94,386,725	183,516,896	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		88,278,638		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)		88,278,638		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0149 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/22/2019 8:09 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	183,516,896	1.00
2.00	Less contractual allowances and discounts on patients' accounts	82,379,141	2.00
3.00	Net patient revenues (line 1 minus line 2)	101,137,755	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	88,278,638	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,859,117	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	87,613	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	479,797	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	390,865	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	6,334	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	647,510	24.00
25.00	Total other income (sum of lines 6-24)	1,612,119	25.00
26.00	Total (line 5 plus line 25)	14,471,236	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)	14,471,236	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0149	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/22/2019 8:09 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	21,248	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	45.79	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	21,248	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00