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: 15-0022	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/30/2019 3:23 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2019 Time: 3:23 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH CRAWFORDSVILLE (15-0022) 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	-95,973	154,971	0	0	1.00
2.00	Subprovider - IPF	0	0	37		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	-95,973	155,008	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: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 3:23 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1710 LAFAYETTE RD	PO Box:			1.00
2.00	City: CRAWFORDSVILLE	State: IN	Zip Code: 47933	County:	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	FRANCISCAN HEALTH CRAWFORDSVILLE	150022	99915	1	01/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	FRANCISCAN HEALTH CRAWFORDSVILLE PSY	15S022	99915	4	01/01/1995	N	P	O	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)	2		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 3:23 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		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.	2		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.	2		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.	1		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.	01/01/2018	12/31/2018	38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	Y	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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 3:23 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 3:23 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	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: 15-0022	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 3:23 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 3:23 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	214,556	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	158014	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 3:23 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: FRANCISCAN ALLIANCE	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1515 DRAGOON TRAIL	PO Box: 1290		142.00
143.00	City: MISHAWAKA	State: IN	Zip Code: 46546-1290	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)	07/03/2018	09/30/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2019 3:23 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	N			5.00

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	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	04/03/2019	Y	04/03/2019	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: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 3:23 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	STEVE	HOWELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	765-428-5927	STEVEN.HOWELL@FRANCISCANALLIANCE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0022	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 3:23 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER REIMBURSEMENT		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: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2019 3:23 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	24	8,760	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)		24	8,760	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	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						13.00
14.00	Total (see instructions)		29	10,585	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	11	4,015		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		40				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: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2019 3:23 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,462	233	2,581			1.00
2.00	HMO and other (see instructions)	650	0				2.00
3.00	HMO IPF Subprovider	377	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)	1,462	233	2,581			7.00
8.00	INTENSIVE CARE UNIT	220	53	450			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)	1,682	286	3,031	0.00	149.59	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,753	68	2,286	0.00	12.89	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	162.48	27.00
28.00	Observation Bed Days		217	1,493			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2019 3:23 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	534	75	856	1.00
2.00	HMO and other (see instructions)			179	0		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	534	75	856	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	125	1	163	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: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2019 3:23 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	15,053,899	814,933	15,868,832	350,893.52	45.22	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,563,936	0	1,563,936	27,812.54	56.23	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,934,492	0	1,934,492	30,235.25	63.98	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		0	0	0	0.00	0.00	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		3,336,538	0	3,336,538	98,725.00	33.80	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,292,388	0	3,292,388			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		365,821	0	365,821			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		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			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)		1,426,661	0	1,426,661			25.50
25.51	Related organization wage-related (core)		0	0	0			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	0	56,373	56,373	0.00	0.00	26.00
27.00	Administrative & General	5.00	4,140,325	544,638	4,684,963	206,294.22	22.71	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2019 3:23 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		98,838	0	98,838	1,070.00	92.37	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	227,496	0	227,496	9,778.93	23.26	30.00
31.00	Laundry & Linen Service	8.00	148,665	0	148,665	8,527.00	17.43	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	363,973	-196,246	167,727	5,346.73	31.37	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	196,246	196,246	12,151.46	16.15	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	277,400	213,922	491,322	3,805.52	129.11	38.00
39.00	Central Services and Supply	14.00	73,851	0	73,851	2,873.21	25.70	39.00
40.00	Pharmacy	15.00	415,120	0	415,120	8,799.55	47.18	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2019 3:23 pm

		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)		15,152,737	814,933	15,967,670	351,963.52	45.37	1.00
2.00	Excluded area salaries (see instructions)		1,563,936	0	1,563,936	27,812.54	56.23	2.00
3.00	Subtotal salaries (line 1 minus line 2)		13,588,801	814,933	14,403,734	324,150.98	44.44	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,271,030	0	5,271,030	128,960.25	40.87	4.00
5.00	Subtotal wage-related costs (see inst.)		4,719,049	0	4,719,049	0.00	32.76	5.00
6.00	Total (sum of lines 3 thru 5)		23,578,880	814,933	24,393,813	453,111.23	53.84	6.00
7.00	Total overhead cost (see instructions)		5,745,668	814,933	6,560,601	258,646.62	25.37	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 5/30/2019 3:23 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	644,863	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,039,330	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	136,863	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	31,120	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	39,166	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	766,867	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	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,658,209	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: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 5/30/2019 3:23 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,934,492	3,658,209	1.00
2.00	Hospital	1,934,492	3,658,209	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/30/2019 3:23 pm

		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)	0.227525	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,039,492	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	30,127,528	6.00
7.00	Medicaid cost (line 1 times line 6)	6,854,766	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)	815,274	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)	815,274	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)	3,504,318	3,553,132	7,057,450	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	797,320	3,553,132	4,350,452	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	797,320	3,553,132	4,350,452	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	6,637,773	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	218,660	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	336,400	27.01
28.00	Non-Medicare bad debt expense (see instructions)	6,301,373	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,551,460	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	5,901,912	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,717,186	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/30/2019 3:23 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,669,297	4,669,297	1,287,000	5,956,297	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		141,158	141,158	1,330	142,488	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,643,615	3,643,615	0	3,643,615	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,140,325	8,558,784	12,699,109	-1,282,009	11,417,100	5.00
7.00	00700	OPERATION OF PLANT	227,496	1,246,835	1,474,331	-5,423	1,468,908	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	148,665	35,693	184,358	-1,486	182,872	8.00
9.00	00900	HOUSEKEEPING	0	555,812	555,812	-3,090	552,722	9.00
10.00	01000	DIETARY	363,973	192,690	556,663	-301,466	255,197	10.00
11.00	01100	CAFETERIA	0	0	0	298,589	298,589	11.00
13.00	01300	NURSING ADMINISTRATION	277,400	164,263	441,663	-14	441,649	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	73,851	76,964	150,815	-66,037	84,778	14.00
15.00	01500	PHARMACY	415,120	1,266,570	1,681,690	-1,218,018	463,672	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,271,106	563,880	1,834,986	-56,453	1,778,533	30.00
31.00	03100	INTENSIVE CARE UNIT	542,776	435,519	978,295	-15,379	962,916	31.00
40.00	04000	SUBPROVIDER - IPF	1,153,934	184,849	1,338,783	-11,758	1,327,025	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,353,136	1,146,252	2,499,388	-903,193	1,596,195	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,104,544	829,685	1,934,229	-111,976	1,822,253	54.00
54.01	05401	ULTRASOUND	131,317	0	131,317	0	131,317	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	502,642	7,578,021	8,080,663	-6,994,067	1,086,596	55.00
56.00	05600	RADIOISOTOPE	79,049	146,665	225,714	-109,158	116,556	56.00
60.00	06000	LABORATORY	0	2,323,780	2,323,780	0	2,323,780	60.00
65.00	06500	RESPIRATORY THERAPY	316,871	149,195	466,066	-26,483	439,583	65.00
66.00	06600	PHYSICAL THERAPY	467,690	59,112	526,802	-3,843	522,959	66.00
69.00	06900	ELECTROCARDIOLOGY	293,186	22,500	315,686	-13,177	302,509	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	995,288	995,288	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	482,982	482,982	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,302,117	8,302,117	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	8,786	8,786	0	8,786	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	145,557	28,892	174,449	-6,508	167,941	90.00
91.00	09100	EMERGENCY	1,635,259	1,195,099	2,830,358	-237,766	2,592,592	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,643,897	35,223,916	49,867,813	2	49,867,815	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	30,265	2,546,861	2,577,126	-2	2,577,124	192.00
194.00	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	160,233	45,434	205,667	0	205,667	194.01
194.02	07952	COMMUNITY IND HEALTH	219,504	25,556	245,060	0	245,060	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	15,053,899	37,841,767	52,895,666	0	52,895,666	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/30/2019 3:23 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,171,810	8,128,107		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	142,488		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	131,378	3,774,993		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,102,646	7,314,454		5.00
7.00	00700	OPERATION OF PLANT	0	1,468,908		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-10,255	172,617		8.00
9.00	00900	HOUSEKEEPING	0	552,722		9.00
10.00	01000	DIETARY	-54,200	200,997		10.00
11.00	01100	CAFETERIA	-106,882	191,707		11.00
13.00	01300	NURSING ADMINISTRATION	295,980	737,629		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	84,778		14.00
15.00	01500	PHARMACY	79,465	543,137		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	467,900	467,900		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,778,533		30.00
31.00	03100	INTENSIVE CARE UNIT	0	962,916		31.00
40.00	04000	SUBPROVIDER - IPF	-239,953	1,087,072		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-21,060	1,575,135		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-19,718	1,802,535		54.00
54.01	05401	ULTRASOUND	0	131,317		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-226,202	860,394		55.00
56.00	05600	RADIOISOTOPE	0	116,556		56.00
60.00	06000	LABORATORY	0	2,323,780		60.00
65.00	06500	RESPIRATORY THERAPY	0	439,583		65.00
66.00	06600	PHYSICAL THERAPY	-13,910	509,049		66.00
69.00	06900	ELECTROCARDIOLOGY	0	302,509		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	995,288		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	482,982		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,302,117		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	8,786		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	167,941		90.00
91.00	09100	EMERGENCY	-2,000	2,590,592		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,650,293	48,217,522		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,577,124		192.00
194.00	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	SPORTS MEDICINE	0	205,667		194.01
194.02	07952	COMMUNITY IND HEALTH	0	245,060		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,650,293	51,245,373		200.00

RECLASSIFICATIONS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 3:23 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAP				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,368	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,330	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	3,466	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	14,164	
	B - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,277,632	1.00
	TOTALS		0	1,277,632	
	C - DIETARY				
1.00	CAFETERIA	11.00	196,246	103,228	1.00
	TOTALS		196,246	103,228	
	D - CHARGEABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	995,288	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
	TOTALS		0	995,288	
	E - DRIGS CHARGED TO PTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	8,302,117	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
	TOTALS		0	8,302,117	
	F - PROTHESIS & IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	482,982	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	482,982	
	G - SHARED SERVICES				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	56,373	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	544,638	0	2.00
3.00	NURSING ADMINISTRATION	13.00	213,922	0	3.00
	TOTALS		814,933	0	
500.00	Grand Total: Increases		1,011,179	11,175,411	500.00

RECLASSIFICATIONS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 3:23 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAP						
1.00	OPERATION OF PLANT	7.00	0	4,906	9		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	0	693	9		2.00
3.00	DIETARY	10.00	0	1,235	0		3.00
4.00	SUBPROVIDER - IPF	40.00	0	1,071	0		4.00
5.00	OPERATING ROOM	50.00	0	2,212	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	57	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	667	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	54	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	1,922	0		10.00
11.00	EMERGENCY	91.00	0	841	0		11.00
12.00	CENTRAL SERVICES & SUPPLY	14.00	0	498	0		12.00
	TOTALS		0	14,164			
	B - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,277,632	11		1.00
	TOTALS		0	1,277,632			
	C - DIETARY						
1.00	DIETARY	10.00	196,246	103,228	0		1.00
	TOTALS		196,246	103,228			
	D - CHARGEABLE SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,003	0		1.00
2.00	OPERATION OF PLANT	7.00	0	517	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	793	0		3.00
4.00	HOUSEKEEPING	9.00	0	3,090	0		4.00
5.00	DIETARY	10.00	0	757	0		5.00
6.00	CAFETERIA	11.00	0	885	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	14	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	65,539	0		8.00
9.00	PHARMACY	15.00	0	38,087	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	59,720	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	15,377	0		11.00
12.00	SUBPROVIDER - IPF	40.00	0	10,687	0		12.00
13.00	OPERATING ROOM	50.00	0	494,535	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	106,353	0		14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	4,594	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	25,731	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	3,788	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	10,488	0		18.00
19.00	CLINIC	90.00	0	6,434	0		19.00
20.00	EMERGENCY	91.00	0	143,894	0		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2	0		21.00
	TOTALS		0	995,288			
	E - DRIGS CHARGED TO PTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	374	0		1.00
2.00	PHARMACY	15.00	0	1,179,931	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	199	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	2	0		4.00
5.00	OPERATING ROOM	50.00	0	12,621	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,615	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	6,989,416	0		7.00
8.00	RADIOISOTOPE	56.00	0	109,158	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	85	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	1	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	767	0		11.00
12.00	CLINIC	90.00	0	74	0		12.00
13.00	EMERGENCY	91.00	0	3,874	0		13.00
	TOTALS		0	8,302,117			
	F - PROTHESIS & IMPLANTS						
1.00	OPERATING ROOM	50.00	0	393,825	0		1.00
2.00	EMERGENCY	91.00	0	89,157	0		2.00
	TOTALS		0	482,982			
	G - SHARED SERVICES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	56,373	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	544,638	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	213,922	0		3.00
	TOTALS		0	814,933			
500.00	Grand Total: Decreases		196,246	11,990,344			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2019 3:23 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	970,120	0	0	0	0	1.00
2.00	Land Improvements	3,795,628	3,181	0	3,181	0	2.00
3.00	Buildings and Fixtures	39,444,492	151,215	0	151,215	0	3.00
4.00	Building Improvements	507,274	0	0	0	0	4.00
5.00	Fixed Equipment	19,623	1,189	0	1,189	0	5.00
6.00	Movable Equipment	20,101,622	1,784,945	0	1,784,945	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	64,838,759	1,940,530	0	1,940,530	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	64,838,759	1,940,530	0	1,940,530	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	970,120	0	1.00
2.00	Land Improvements	3,798,809	0	2.00
3.00	Buildings and Fixtures	39,595,707	0	3.00
4.00	Building Improvements	507,274	0	4.00
5.00	Fixed Equipment	20,812	0	5.00
6.00	Movable Equipment	21,886,567	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	66,779,289	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	66,779,289	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2019 3:23 pm

	Cost Center Description	SUMMARY OF CAPITAL: Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,221,993	447,304	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	141,158	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,221,993	588,462	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	4,669,297				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	141,158				2.00
3.00	Total (sum of lines 1-2)	0	4,810,455				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2019 3:23 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	4,848,205	0	4,848,205	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	4,848,205	0	4,848,205	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,937,628	1,920,335	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,330	141,158	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,938,958	2,061,493	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,270,144	0	0	0	8,128,107	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	142,488	2.00
3.00	Total (sum of lines 1-2)	1,270,144	0	0	0	8,270,595	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/30/2019 3:23 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-7,488	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	-177,547	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	-505,626			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	2,747,798			0	12.00
13.00	Laundry and linen service	B	-10,255	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-106,882	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-26,841	ADMINISTRATIVE & GENERAL	5.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,493	ADMINISTRATIVE & GENERAL	5.00	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	-7,545	DIETARY	10.00	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	MISC INCOME	B	-21,200	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/30/2019 3:23 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME	B	-46,600	DIETARY	10.00	0	33.01
33.02	MISC INCOME		0		0.00	0	33.02
33.03	MISC INCOME	B	-13,910	PHYSICAL THERAPY	66.00	0	33.03
33.04	MISC INCOME	B	-3,307	RADIOLOGY-THERAPEUTIC	55.00	0	33.04
33.05	MISC INCOME	B	-424	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	MISC INCOME	B	-55	DIETARY	10.00	0	33.06
33.07	ADVERTISING EXPENSE		0		0.00	0	33.07
33.08	HAF ASSESSMENT	A	-2,384,507	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	PENSION ADJ	A	193,221	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	INTEREST EXP	A	-1,277,632	ADMINISTRATIVE & GENERAL	5.00	11	33.10
33.11	MISC INCOME		0		0.00	0	33.11
33.12	MISC INCOME		0		0.00	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,650,293				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: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2019 3:23 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	FA-INT	2,750,663	1,277,632	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	FA-NEW CAP	706,267	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	FA A&G	5,729,494	7,023,123	3.00
4.00	15.00	PHARMACY	PHARMACY	79,465	0	4.00
4.04	16.00	MEDICAL RECORDS & LIBRARY	FA-HIM	467,900	0	4.04
4.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	FSEH SHARED SERVICES	131,378	0	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	FSEH SHARED SERVICES	887,406	0	4.08
4.09	13.00	NURSING ADMINISTRATION	FSEH SHARED SERVICES	295,980	0	4.09
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,048,553	8,300,755	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	HOME OFFICE	100.00		0.00	6.00
7.00		SISTER FACILITY	0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0022	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/30/2019 3:23 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,473,031	10		1.00
2.00	706,267	9		2.00
3.00	-1,293,629	0		3.00
4.00	79,465	0		4.00
4.04	467,900	0		4.04
4.07	131,378	0		4.07
4.08	887,406	0		4.08
4.09	295,980	0		4.09
5.00	2,747,798			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2019 3:23 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	40.00	SUBPROVIDER - IPF	239,953	239,953	0	197,500	0	1.00
2.00	50.00	OPERATING ROOM	21,060	21,060	0	197,500	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	19,718	19,718	0	197,500	0	3.00
4.00	55.00	RADIOLOGY-THERAPEUTIC	222,895	222,895	0	197,500	0	4.00
5.00	91.00	EMERGENCY	2,000	2,000	0	197,500	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			505,626	505,626	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	40.00	SUBPROVIDER - IPF	0	0	0	239,953		1.00
2.00	50.00	OPERATING ROOM	0	0	0	21,060		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	19,718		3.00
4.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	222,895		4.00
5.00	91.00	EMERGENCY	0	0	0	2,000		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	505,626		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/30/2019 3:23 pm

		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	8,128,107	8,128,107				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	142,488		142,488			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,774,993	49,972	876	3,825,841		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,314,454	1,049,069	18,390	1,052,232	9,434,145	5.00
7.00	00700	OPERATION OF PLANT	1,468,908	549,071	9,625	57,817	2,085,421	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	172,617	213,850	3,749	37,782	427,998	8.00
9.00	00900	HOUSEKEEPING	552,722	17,072	299	0	570,093	9.00
10.00	01000	DIETARY	200,997	212,952	3,733	92,501	510,183	10.00
11.00	01100	CAFETERIA	191,707	116,809	2,048	0	310,564	11.00
13.00	01300	NURSING ADMINISTRATION	737,629	70,016	1,227	70,499	879,371	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	84,778	391,275	6,859	18,769	501,681	14.00
15.00	01500	PHARMACY	543,137	20,735	363	105,500	669,735	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	467,900	133,743	2,345	0	603,988	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,778,533	1,087,087	19,058	323,043	3,207,721	30.00
31.00	03100	INTENSIVE CARE UNIT	962,916	129,872	2,277	137,943	1,233,008	31.00
40.00	04000	SUBPROVIDER - IPF	1,087,072	297,897	5,222	293,264	1,683,455	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,575,135	433,576	7,601	343,890	2,360,202	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,802,535	1,069,804	18,754	280,712	3,171,805	54.00
54.01	05401	ULTRASOUND	131,317	19,422	340	33,373	184,452	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	860,394	0	0	127,743	988,137	55.00
56.00	05600	RADIOISOTOPE	116,556	18,454	324	20,090	155,424	56.00
60.00	06000	LABORATORY	2,323,780	372,268	6,526	0	2,702,574	60.00
65.00	06500	RESPIRATORY THERAPY	439,583	28,062	492	80,531	548,668	65.00
66.00	06600	PHYSICAL THERAPY	509,049	160,975	2,822	118,860	791,706	66.00
69.00	06900	ELECTROCARDIOLOGY	302,509	22,325	391	74,511	399,736	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	995,288	97,594	1,711	0	1,094,593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	482,982	0	0	0	482,982	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,302,117	295,202	5,175	0	8,602,494	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	8,786	0	0	0	8,786	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	167,941	58,819	1,031	36,992	264,783	90.00
91.00	09100	EMERGENCY	2,590,592	790,707	13,861	415,590	3,810,750	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,217,522	7,706,628	135,099	3,721,642	47,684,455	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,260	425	0	24,685	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,577,124	0	0	7,692	2,584,816	192.00
194.00	07953	OTHER NONREIMBURSABLE COST CENTERS	0	284,972	4,996	0	289,968	194.00
194.01	07951	SPORTS MEDICINE	205,667	0	0	40,722	246,389	194.01
194.02	07952	COMMUNITY IND HEALTH	245,060	112,247	1,968	55,785	415,060	194.02
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)	51,245,373	8,128,107	142,488	3,825,841	51,245,373	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 3:23 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,434,145					5.00
7.00	00700	OPERATION OF PLANT	470,548	2,555,969				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	96,572	84,351	608,921			8.00
9.00	00900	HOUSEKEEPING	128,634	6,734	67,507	772,968		9.00
10.00	01000	DIETARY	115,116	83,997	4,091	26,341	739,728	10.00
11.00	01100	CAFETERIA	70,075	46,074	0	14,448	0	11.00
13.00	01300	NURSING ADMINISTRATION	198,419	27,617	0	8,661	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	113,198	154,335	2,247	48,398	0	14.00
15.00	01500	PHARMACY	151,117	8,179	0	2,565	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	136,282	52,754	0	16,543	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	723,781	428,787	184,661	134,465	359,020	30.00
31.00	03100	INTENSIVE CARE UNIT	278,212	51,227	17,318	16,064	62,726	31.00
40.00	04000	SUBPROVIDER - IPF	379,850	117,503	56,800	36,848	317,982	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	532,549	171,020	81,350	53,630	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	715,677	421,974	22,635	132,328	0	54.00
54.01	05401	ULTRASOUND	41,619	7,661	0	2,402	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	222,960	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	35,069	7,279	0	2,283	0	56.00
60.00	06000	LABORATORY	609,801	146,837	0	46,047	0	60.00
65.00	06500	RESPIRATORY THERAPY	123,800	11,069	3,135	3,471	0	65.00
66.00	06600	PHYSICAL THERAPY	178,638	63,495	15,821	19,912	0	66.00
69.00	06900	ELECTROCARDIOLOGY	90,195	8,806	0	2,761	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	246,981	38,495	0	12,072	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	108,979	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,941,025	116,439	0	36,514	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,982	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	59,745	23,201	0	7,276	0	90.00
91.00	09100	EMERGENCY	859,846	311,886	153,356	97,805	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,630,670	2,389,720	608,921	720,834	739,728	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,570	9,569	0	3,001	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	583,230	0	0	0	0	192.00
194.00	07953	OTHER NONREIMBURSABLE COST CENTERS	65,428	112,405	0	35,249	0	194.00
194.01	07951	SPORTS MEDICINE	55,594	0	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	93,653	44,275	0	13,884	0	194.02
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)	9,434,145	2,555,969	608,921	772,968	739,728	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/30/2019 3:23 pm

		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	441,161					11.00
13.00	01300	NURSING ADMINISTRATION	548	1,114,616				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,077	10,298	834,234			14.00
15.00	01500	PHARMACY	12,869	32,557	0	877,022		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	809,567	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,458	158,005	0	0	30,129	30.00
31.00	03100	INTENSIVE CARE UNIT	21,144	53,490	0	0	7,032	31.00
40.00	04000	SUBPROVIDER - IPF	40,675	102,904	0	0	19,614	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	62,428	157,955	0	0	69,780	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,133	124,314	0	0	159,536	54.00
54.01	05401	ULTRASOUND	5,811	14,664	0	0	15,663	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	29,753	75,244	0	0	25,361	55.00
56.00	05600	RADIOISOTOPE	3,042	7,728	0	0	12,197	56.00
60.00	06000	LABORATORY	0	0	0	0	98,716	60.00
65.00	06500	RESPIRATORY THERAPY	15,090	38,181	0	0	12,233	65.00
66.00	06600	PHYSICAL THERAPY	21,661	54,807	0	0	11,009	66.00
69.00	06900	ELECTROCARDIOLOGY	14,542	36,786	0	0	27,189	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	592,306	0	2,399	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	241,928	0	18,935	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	877,022	174,090	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	307	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,598	14,131	0	0	3,487	90.00
91.00	09100	EMERGENCY	72,831	184,253	0	0	121,890	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	421,660	1,065,317	834,234	877,022	809,567	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	2,708	6,830	0	0	0	192.00
194.00	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	9,096	23,034	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	7,697	19,435	0	0	0	194.02
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)	441,161	1,114,616	834,234	877,022	809,567	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 3:23 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,289,027	0	5,289,027		30.00
31.00	03100	INTENSIVE CARE UNIT	1,740,221	0	1,740,221		31.00
40.00	04000	SUBPROVIDER - IPF	2,755,631	0	2,755,631		40.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,488,914	0	3,488,914		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,797,402	0	4,797,402		54.00
54.01	05401	ULTRASOUND	272,272	0	272,272		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,341,455	0	1,341,455		55.00
56.00	05600	RADIOISOTOPE	223,022	0	223,022		56.00
60.00	06000	LABORATORY	3,603,975	0	3,603,975		60.00
65.00	06500	RESPIRATORY THERAPY	755,647	0	755,647		65.00
66.00	06600	PHYSICAL THERAPY	1,157,049	0	1,157,049		66.00
69.00	06900	ELECTROCARDIOLOGY	580,015	0	580,015		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,986,846	0	1,986,846		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	852,824	0	852,824		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,747,584	0	11,747,584		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	11,075	0	11,075		76.98
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	378,221	0	378,221		90.00
91.00	09100	EMERGENCY	5,612,617	0	5,612,617		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,593,797	0	46,593,797		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	42,825	0	42,825		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,177,584	0	3,177,584		192.00
194.00	07953	OTHER NONREIMBURSABLE COST CENTERS	503,050	0	503,050		194.00
194.01	07951	SPORTS MEDICINE	334,113	0	334,113		194.01
194.02	07952	COMMUNITY IND HEALTH	594,004	0	594,004		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	51,245,373	0	51,245,373		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 3:23 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	49,972	876	50,848	50,848	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,049,069	18,390	1,067,459	13,984	5.00
7.00	00700	OPERATION OF PLANT	0	549,071	9,625	558,696	768	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	213,850	3,749	217,599	502	8.00
9.00	00900	HOUSEKEEPING	0	17,072	299	17,371	0	9.00
10.00	01000	DIETARY	0	212,952	3,733	216,685	1,230	10.00
11.00	01100	CAFETERIA	0	116,809	2,048	118,857	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	70,016	1,227	71,243	937	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	391,275	6,859	398,134	249	14.00
15.00	01500	PHARMACY	0	20,735	363	21,098	1,402	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	133,743	2,345	136,088	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,087,087	19,058	1,106,145	4,294	30.00
31.00	03100	INTENSIVE CARE UNIT	0	129,872	2,277	132,149	1,833	31.00
40.00	04000	SUBPROVIDER - IPF	0	297,897	5,222	303,119	3,898	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	433,576	7,601	441,177	4,571	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,069,804	18,754	1,088,558	3,731	54.00
54.01	05401	ULTRASOUND	0	19,422	340	19,762	444	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	1,698	55.00
56.00	05600	RADIOISOTOPE	0	18,454	324	18,778	267	56.00
60.00	06000	LABORATORY	0	372,268	6,526	378,794	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	28,062	492	28,554	1,070	65.00
66.00	06600	PHYSICAL THERAPY	0	160,975	2,822	163,797	1,580	66.00
69.00	06900	ELECTROCARDIOLOGY	0	22,325	391	22,716	990	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	97,594	1,711	99,305	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	295,202	5,175	300,377	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	58,819	1,031	59,850	492	90.00
91.00	09100	EMERGENCY	0	790,707	13,861	804,568	5,524	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,706,628	135,099	7,841,727	49,464	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,260	425	24,685	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	102	192.00
194.00	07953	OTHER NONREIMBURSABLE COST CENTERS	0	284,972	4,996	289,968	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	541	194.01
194.02	07952	COMMUNITY IND HEALTH	0	112,247	1,968	114,215	741	194.02
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	8,128,107	142,488	8,270,595	50,848	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 3:23 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,081,443					5.00
7.00	00700	OPERATION OF PLANT	53,939	613,403				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,070	20,243	249,414			8.00
9.00	00900	HOUSEKEEPING	14,745	1,616	27,651	61,383		9.00
10.00	01000	DIETARY	13,196	20,158	1,676	2,092	255,037	10.00
11.00	01100	CAFETERIA	8,033	11,057	0	1,147	0	11.00
13.00	01300	NURSING ADMINISTRATION	22,745	6,628	0	688	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,976	37,039	920	3,843	0	14.00
15.00	01500	PHARMACY	17,323	1,963	0	204	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,622	12,660	0	1,314	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	82,968	102,905	75,638	10,677	123,780	30.00
31.00	03100	INTENSIVE CARE UNIT	31,892	12,294	7,093	1,276	21,626	31.00
40.00	04000	SUBPROVIDER - IPF	43,543	28,199	23,265	2,926	109,631	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,047	41,043	33,321	4,259	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	82,039	101,269	9,271	10,508	0	54.00
54.01	05401	ULTRASOUND	4,771	1,839	0	191	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	25,558	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	4,020	1,747	0	181	0	56.00
60.00	06000	LABORATORY	69,902	35,239	0	3,657	0	60.00
65.00	06500	RESPIRATORY THERAPY	14,191	2,656	1,284	276	0	65.00
66.00	06600	PHYSICAL THERAPY	20,477	15,238	6,480	1,581	0	66.00
69.00	06900	ELECTROCARDIOLOGY	10,339	2,113	0	219	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,312	9,238	0	959	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,492	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	222,499	27,944	0	2,900	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	227	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,849	5,568	0	578	0	90.00
91.00	09100	EMERGENCY	98,565	74,849	62,815	7,767	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	989,340	573,505	249,414	57,243	255,037	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	638	2,297	0	238	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	66,856	0	0	0	0	192.00
194.00	07953	OTHER NONREIMBURSABLE COST CENTERS	7,500	26,976	0	2,799	0	194.00
194.01	07951	SPORTS MEDICINE	6,373	0	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	10,736	10,625	0	1,103	0	194.02
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)	1,081,443	613,403	249,414	61,383	255,037	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 3:23 pm

		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	139,094					11.00
13.00	01300	NURSING ADMINISTRATION	173	102,414				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,285	946	455,392			14.00
15.00	01500	PHARMACY	4,057	2,992	0	49,039		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	165,684	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,692	14,520	0	0	6,166	30.00
31.00	03100	INTENSIVE CARE UNIT	6,666	4,915	0	0	1,439	31.00
40.00	04000	SUBPROVIDER - IPF	12,825	9,456	0	0	4,014	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,683	14,515	0	0	14,281	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,491	11,424	0	0	32,650	54.00
54.01	05401	ULTRASOUND	1,832	1,348	0	0	3,206	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	9,381	6,915	0	0	5,190	55.00
56.00	05600	RADIOISOTOPE	959	710	0	0	2,496	56.00
60.00	06000	LABORATORY	0	0	0	0	20,203	60.00
65.00	06500	RESPIRATORY THERAPY	4,758	3,509	0	0	2,504	65.00
66.00	06600	PHYSICAL THERAPY	6,830	5,036	0	0	2,253	66.00
69.00	06900	ELECTROCARDIOLOGY	4,585	3,380	0	0	5,564	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	323,328	0	491	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	132,064	0	3,875	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	49,039	35,630	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	63	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,765	1,299	0	0	714	90.00
91.00	09100	EMERGENCY	22,963	16,918	0	0	24,945	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	132,945	97,883	455,392	49,039	165,684	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	854	628	0	0	0	192.00
194.00	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	2,868	2,117	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	2,427	1,786	0	0	0	194.02
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)	139,094	102,414	455,392	49,039	165,684	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 3:23 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,546,785	0	1,546,785		30.00
31.00	03100	INTENSIVE CARE UNIT	221,183	0	221,183		31.00
40.00	04000	SUBPROVIDER - IPF	540,876	0	540,876		40.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	633,897	0	633,897		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,354,941	0	1,354,941		54.00
54.01	05401	ULTRASOUND	33,393	0	33,393		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	48,742	0	48,742		55.00
56.00	05600	RADIOISOTOPE	29,158	0	29,158		56.00
60.00	06000	LABORATORY	507,795	0	507,795		60.00
65.00	06500	RESPIRATORY THERAPY	58,802	0	58,802		65.00
66.00	06600	PHYSICAL THERAPY	223,272	0	223,272		66.00
69.00	06900	ELECTROCARDIOLOGY	49,906	0	49,906		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	461,633	0	461,633		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	148,431	0	148,431		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	638,389	0	638,389		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	290	0	290		76.98
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	77,115	0	77,115		90.00
91.00	09100	EMERGENCY	1,118,914	0	1,118,914		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,693,522	0	7,693,522		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,858	0	27,858		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	68,440	0	68,440		192.00
194.00	07953	OTHER NONREIMBURSABLE COST CENTERS	327,243	0	327,243		194.00
194.01	07951	SPORTS MEDICINE	11,899	0	11,899		194.01
194.02	07952	COMMUNITY IND HEALTH	141,633	0	141,633		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	8,270,595	0	8,270,595		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 3:23 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	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	117,598					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		117,598				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	723	723	15,053,899			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,178	15,178	4,140,325	-9,434,145	41,811,228	5.00
7.00	00700	OPERATION OF PLANT	7,944	7,944	227,496	0	2,085,421	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,094	3,094	148,665	0	427,998	8.00
9.00	00900	HOUSEKEEPING	247	247	0	0	570,093	9.00
10.00	01000	DIETARY	3,081	3,081	363,973	0	510,183	10.00
11.00	01100	CAFETERIA	1,690	1,690	0	0	310,564	11.00
13.00	01300	NURSING ADMINISTRATION	1,013	1,013	277,400	0	879,371	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,661	5,661	73,851	0	501,681	14.00
15.00	01500	PHARMACY	300	300	415,120	0	669,735	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,935	1,935	0	0	603,988	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,728	15,728	1,271,106	0	3,207,721	30.00
31.00	03100	INTENSIVE CARE UNIT	1,879	1,879	542,776	0	1,233,008	31.00
40.00	04000	SUBPROVIDER - IPF	4,310	4,310	1,153,934	0	1,683,455	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,273	6,273	1,353,136	0	2,360,202	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,478	15,478	1,104,544	0	3,171,805	54.00
54.01	05401	ULTRASOUND	281	281	131,317	0	184,452	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	502,642	0	988,137	55.00
56.00	05600	RADIOISOTOPE	267	267	79,049	0	155,424	56.00
60.00	06000	LABORATORY	5,386	5,386	0	0	2,702,574	60.00
65.00	06500	RESPIRATORY THERAPY	406	406	316,871	0	548,668	65.00
66.00	06600	PHYSICAL THERAPY	2,329	2,329	467,690	0	791,706	66.00
69.00	06900	ELECTROCARDIOLOGY	323	323	293,186	0	399,736	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,412	1,412	0	0	1,094,593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	482,982	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,271	4,271	0	0	8,602,494	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	8,786	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	851	851	145,557	0	264,783	90.00
91.00	09100	EMERGENCY	11,440	11,440	1,635,259	0	3,810,750	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,500	111,500	14,643,897	-9,434,145	38,250,310	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	351	351	0	0	24,685	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	30,265	0	2,584,816	192.00
194.00	07953	OTHER NONREIMBURSABLE COST CENTERS	4,123	4,123	0	0	289,968	194.00
194.01	07951	SPORTS MEDICINE	0	0	160,233	0	246,389	194.01
194.02	07952	COMMUNITY IND HEALTH	1,624	1,624	219,504	0	415,060	194.02
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)	8,128,107	142,488	3,825,841		9,434,145	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	69.117732	1.211653	0.254143		0.225637	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			50,848		1,081,443	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003378		0.025865	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: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 3:23 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	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	93,753					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,094	252,282				8.00
9.00	00900	HOUSEKEEPING	247	27,969	90,412			9.00
10.00	01000	DIETARY	3,081	1,695	3,081	22,442		10.00
11.00	01100	CAFETERIA	1,690	0	1,690	0	14,501	11.00
13.00	01300	NURSING ADMINISTRATION	1,013	0	1,013	0	18	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,661	931	5,661	0	134	14.00
15.00	01500	PHARMACY	300	0	300	0	423	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,935	0	1,935	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,728	76,506	15,728	10,892	2,053	30.00
31.00	03100	INTENSIVE CARE UNIT	1,879	7,175	1,879	1,903	695	31.00
40.00	04000	SUBPROVIDER - IPF	4,310	23,533	4,310	9,647	1,337	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,273	33,704	6,273	0	2,052	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,478	9,378	15,478	0	1,615	54.00
54.01	05401	ULTRASOUND	281	0	281	0	191	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	978	55.00
56.00	05600	RADIOISOTOPE	267	0	267	0	100	56.00
60.00	06000	LABORATORY	5,386	0	5,386	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	406	1,299	406	0	496	65.00
66.00	06600	PHYSICAL THERAPY	2,329	6,555	2,329	0	712	66.00
69.00	06900	ELECTROCARDIOLOGY	323	0	323	0	478	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,412	0	1,412	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	4,271	0	4,271	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	851	0	851	0	184	90.00
91.00	09100	EMERGENCY	11,440	63,537	11,440	0	2,394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,655	252,282	84,314	22,442	13,860	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	351	0	351	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	89	192.00
194.00	07953	OTHER NONREIMBURSABLE COST CENTERS	4,123	0	4,123	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	299	194.01
194.02	07952	COMMUNITY IND HEALTH	1,624	0	1,624	0	253	194.02
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)	2,555,969	608,921	772,968	739,728	441,161	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.262797	2.413652	8.549396	32.961768	30.422798	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	613,403	249,414	61,383	255,037	139,094	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.542756	0.988632	0.678925	11.364272	9.592028	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: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 3:23 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			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						11.00
13.00	01300	NURSING ADMINISTRATION	30,125,497					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	278,321	100				14.00
15.00	01500	PHARMACY	879,955	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	204,785,236		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,270,508	0	0	7,621,756		30.00
31.00	03100	INTENSIVE CARE UNIT	1,445,719	0	0	1,778,826		31.00
40.00	04000	SUBPROVIDER - IPF	2,781,254	0	0	4,961,845		40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,269,157	0	0	17,652,344		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,359,933	0	0	40,358,311		54.00
54.01	05401	ULTRASOUND	396,325	0	0	3,962,420		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,033,681	0	0	6,415,617		55.00
56.00	05600	RADIOISOTOPE	208,860	0	0	3,085,461		56.00
60.00	06000	LABORATORY	0	0	0	24,972,459		60.00
65.00	06500	RESPIRATORY THERAPY	1,031,947	0	0	3,094,710		65.00
66.00	06600	PHYSICAL THERAPY	1,481,322	0	0	2,785,016		66.00
69.00	06900	ELECTROCARDIOLOGY	994,251	0	0	6,878,046		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71	0	607,001		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	29	0	4,790,010		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	44,026,805		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	77,577		76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	381,925	0	0	882,138		90.00
91.00	09100	EMERGENCY	4,979,898	0	0	30,834,894		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,793,056	100	100	204,785,236		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	184,600	0	0	0		192.00
194.00	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	SPORTS MEDICINE	622,550	0	0	0		194.01
194.02	07952	COMMUNITY IND HEALTH	525,291	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,114,616	834,234	877,022	809,567		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.036999	8,342.340000	8,770.220000	0.003953		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	102,414	455,392	49,039	165,684		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003400	4,553.920000	490.390000	0.000809		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: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,289,027		5,289,027	0	5,289,027	30.00
31.00	03100	INTENSIVE CARE UNIT	1,740,221		1,740,221	0	1,740,221	31.00
40.00	04000	SUBPROVIDER - IPF	2,755,631		2,755,631	0	2,755,631	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,488,914		3,488,914	0	3,488,914	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,797,402		4,797,402	0	4,797,402	54.00
54.01	05401	ULTRASOUND	272,272		272,272	0	272,272	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,341,455		1,341,455	0	1,341,455	55.00
56.00	05600	RADIOISOTOPE	223,022		223,022	0	223,022	56.00
60.00	06000	LABORATORY	3,603,975		3,603,975	0	3,603,975	60.00
65.00	06500	RESPIRATORY THERAPY	755,647	0	755,647	0	755,647	65.00
66.00	06600	PHYSICAL THERAPY	1,157,049	0	1,157,049	0	1,157,049	66.00
69.00	06900	ELECTROCARDIOLOGY	580,015		580,015	0	580,015	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,986,846		1,986,846	0	1,986,846	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	852,824		852,824	0	852,824	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,747,584		11,747,584	0	11,747,584	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	11,075		11,075	0	11,075	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	378,221		378,221	0	378,221	90.00
91.00	09100	EMERGENCY	5,612,617		5,612,617	0	5,612,617	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,938,272		1,938,272		1,938,272	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	48,532,069	0	48,532,069	0	48,532,069	200.00
201.00		Less Observation Beds	1,938,272		1,938,272		1,938,272	201.00
202.00		Total (see instructions)	46,593,797	0	46,593,797	0	46,593,797	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 3:23 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,776,782		3,776,782			30.00
31.00	03100	INTENSIVE CARE UNIT	1,719,574		1,719,574			31.00
40.00	04000	SUBPROVIDER - IPF	4,770,834		4,770,834			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,246,246	14,078,504	16,324,750	0.213719	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,521,084	35,745,877	39,266,961	0.122174	0.000000	54.00
54.01	05401	ULTRASOUND	280,226	3,672,648	3,952,874	0.068880	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	31,858	6,155,622	6,187,480	0.216802	0.000000	55.00
56.00	05600	RADIOISOTOPE	101,196	2,523,737	2,624,933	0.084963	0.000000	56.00
60.00	06000	LABORATORY	4,821,786	19,181,340	24,003,126	0.150146	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,507,932	821,561	2,329,493	0.324383	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	371,945	2,413,071	2,785,016	0.415455	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	961,066	5,864,472	6,825,538	0.084977	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,463,027	5,222,023	6,685,050	0.297207	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	801,834	3,988,176	4,790,010	0.178042	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,569,709	38,457,096	44,026,805	0.266828	0.000000	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	77,577	77,577	0.142761	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	882,138	882,138	0.428755	0.000000	90.00
91.00	09100	EMERGENCY	2,435,078	27,418,563	29,853,641	0.188004	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,902,654	3,902,654	0.496655	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	34,380,177	170,405,059	204,785,236			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	34,380,177	170,405,059	204,785,236			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 3:23 pm

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.213719		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122174		54.00
54.01	05401	ULTRASOUND	0.068880		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.216802		55.00
56.00	05600	RADIOISOTOPE	0.084963		56.00
60.00	06000	LABORATORY	0.150146		60.00
65.00	06500	RESPIRATORY THERAPY	0.324383		65.00
66.00	06600	PHYSICAL THERAPY	0.415455		66.00
69.00	06900	ELECTROCARDIOLOGY	0.084977		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297207		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.178042		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266828		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.142761		76.98
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.428755		90.00
91.00	09100	EMERGENCY	0.188004		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.496655		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 3:23 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,289,027		5,289,027	0	5,289,027	30.00
31.00	03100	INTENSIVE CARE UNIT	1,740,221		1,740,221	0	1,740,221	31.00
40.00	04000	SUBPROVIDER - IPF	2,755,631		2,755,631	0	2,755,631	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,488,914		3,488,914	0	3,488,914	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,797,402		4,797,402	0	4,797,402	54.00
54.01	05401	ULTRASOUND	272,272		272,272	0	272,272	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,341,455		1,341,455	0	1,341,455	55.00
56.00	05600	RADIOISOTOPE	223,022		223,022	0	223,022	56.00
60.00	06000	LABORATORY	3,603,975		3,603,975	0	3,603,975	60.00
65.00	06500	RESPIRATORY THERAPY	755,647	0	755,647	0	755,647	65.00
66.00	06600	PHYSICAL THERAPY	1,157,049	0	1,157,049	0	1,157,049	66.00
69.00	06900	ELECTROCARDIOLOGY	580,015		580,015	0	580,015	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,986,846		1,986,846	0	1,986,846	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	852,824		852,824	0	852,824	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,747,584		11,747,584	0	11,747,584	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	11,075		11,075	0	11,075	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	378,221		378,221	0	378,221	90.00
91.00	09100	EMERGENCY	5,612,617		5,612,617	0	5,612,617	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,938,272		1,938,272		1,938,272	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	48,532,069	0	48,532,069	0	48,532,069	200.00
201.00		Less Observation Beds	1,938,272		1,938,272		1,938,272	201.00
202.00		Total (see instructions)	46,593,797	0	46,593,797	0	46,593,797	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 3:23 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,776,782		3,776,782			30.00
31.00	03100	INTENSIVE CARE UNIT	1,719,574		1,719,574			31.00
40.00	04000	SUBPROVIDER - IPF	4,770,834		4,770,834			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,246,246	14,078,504	16,324,750	0.213719	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,521,084	35,745,877	39,266,961	0.122174	0.000000	54.00
54.01	05401	ULTRASOUND	280,226	3,672,648	3,952,874	0.068880	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	31,858	6,155,622	6,187,480	0.216802	0.000000	55.00
56.00	05600	RADIOISOTOPE	101,196	2,523,737	2,624,933	0.084963	0.000000	56.00
60.00	06000	LABORATORY	4,821,786	19,181,340	24,003,126	0.150146	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,507,932	821,561	2,329,493	0.324383	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	371,945	2,413,071	2,785,016	0.415455	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	961,066	5,864,472	6,825,538	0.084977	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,463,027	5,222,023	6,685,050	0.297207	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	801,834	3,988,176	4,790,010	0.178042	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,569,709	38,457,096	44,026,805	0.266828	0.000000	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	77,577	77,577	0.142761	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	882,138	882,138	0.428755	0.000000	90.00
91.00	09100	EMERGENCY	2,435,078	27,418,563	29,853,641	0.188004	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,902,654	3,902,654	0.496655	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	34,380,177	170,405,059	204,785,236			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	34,380,177	170,405,059	204,785,236			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 3:23 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,546,785	0	1,546,785	4,074	379.67	30.00
31.00	INTENSIVE CARE UNIT	221,183		221,183	450	491.52	31.00
40.00	SUBPROVIDER - IPF	540,876	0	540,876	2,286	236.60	40.00
200.00	Total (lines 30 through 199)	2,308,844		2,308,844	6,810		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	1,462	555,078	30.00
31.00	INTENSIVE CARE UNIT	220	108,134	31.00
40.00	SUBPROVIDER - IPF	1,753	414,760	40.00
200.00	Total (lines 30 through 199)	3,435	1,077,972	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	633,897	16,324,750	0.038830	1,531,304	59,461	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,354,941	39,266,961	0.034506	2,008,269	69,297	54.00
54.01	05401	ULTRASOUND	33,393	3,952,874	0.008448	164,690	1,391	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	48,742	6,187,480	0.007878	31,858	251	55.00
56.00	05600	RADIOISOTOPE	29,158	2,624,933	0.011108	71,955	799	56.00
60.00	06000	LABORATORY	507,795	24,003,126	0.021155	2,729,785	57,749	60.00
65.00	06500	RESPIRATORY THERAPY	58,802	2,329,493	0.025242	1,015,496	25,633	65.00
66.00	06600	PHYSICAL THERAPY	223,272	2,785,016	0.080169	204,918	16,428	66.00
69.00	06900	ELECTROCARDIOLOGY	49,906	6,825,538	0.007312	530,284	3,877	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	461,633	6,685,050	0.069055	106,229	7,336	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	148,431	4,790,010	0.030988	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	638,389	44,026,805	0.014500	2,907,760	42,163	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	290	77,577	0.003738	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	77,115	882,138	0.087418	0	0	90.00
91.00	09100	EMERGENCY	1,118,914	29,853,641	0.037480	1,279,361	47,950	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	566,852	3,902,654	0.145248	0	0	92.00
200.00		Total (lines 50 through 199)	5,951,530	194,518,046		12,581,909	332,335	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,074	0.00	1,462	30.00
31.00	03100	INTENSIVE CARE UNIT		0	450	0.00	220	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	2,286	0.00	1,753	40.00
200.00		Total (lines 30 through 199)		0	6,810		3,435	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		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: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	16,324,750	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	39,266,961	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	3,952,874	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	6,187,480	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,624,933	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	24,003,126	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,329,493	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,785,016	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,825,538	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,685,050	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,790,010	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	44,026,805	0.000000	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	77,577	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	882,138	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	29,853,641	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,902,654	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	194,518,046		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,531,304	0	5,738,477	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,008,269	0	10,835,268	0	54.00
54.01	05401	ULTRASOUND	0.000000	164,690	0	1,092,674	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	31,858	0	2,677,433	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	71,955	0	1,083,318	0	56.00
60.00	06000	LABORATORY	0.000000	2,729,785	0	4,161,830	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,015,496	0	456,763	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	204,918	0	40,433	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	530,284	0	2,162,881	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	106,229	0	95,537	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,907,760	0	15,215,080	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	77,463	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	403,708	0	90.00
91.00	09100	EMERGENCY	0.000000	1,279,361	0	7,146,511	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	1,458,060	0	92.00
200.00		Total (lines 50 through 199)		12,581,909	0	52,645,436	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 3:23 pm

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		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	0.213719	5,738,477	0	0	1,226,422	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122174	10,835,268	0	0	1,323,788	54.00
54.01	05401	ULTRASOUND	0.068880	1,092,674	0	0	75,263	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.216802	2,677,433	0	0	580,473	55.00
56.00	05600	RADIOISOTOPE	0.084963	1,083,318	0	0	92,042	56.00
60.00	06000	LABORATORY	0.150146	4,161,830	0	0	624,882	60.00
65.00	06500	RESPIRATORY THERAPY	0.324383	456,763	0	0	148,166	65.00
66.00	06600	PHYSICAL THERAPY	0.415455	40,433	0	0	16,798	66.00
69.00	06900	ELECTROCARDIOLOGY	0.084977	2,162,881	0	0	183,795	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297207	95,537	0	0	28,394	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.178042	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266828	15,215,080	0	2,402	4,059,809	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.142761	77,463	0	0	11,059	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.428755	403,708	0	0	173,092	90.00
91.00	09100	EMERGENCY	0.188004	7,146,511	0	0	1,343,573	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.496655	1,458,060	0	0	724,153	92.00
200.00		Subtotal (see instructions)		52,645,436	0	2,402	10,611,709	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		52,645,436	0	2,402	10,611,709	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	641		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		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	641		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	641		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	633,897	16,324,750	0.038830	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,354,941	39,266,961	0.034506	75,806	2,616	54.00
54.01	05401	ULTRASOUND	33,393	3,952,874	0.008448	16,731	141	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	48,742	6,187,480	0.007878	0	0	55.00
56.00	05600	RADIOISOTOPE	29,158	2,624,933	0.011108	6,850	76	56.00
60.00	06000	LABORATORY	507,795	24,003,126	0.021155	424,608	8,983	60.00
65.00	06500	RESPIRATORY THERAPY	58,802	2,329,493	0.025242	25,930	655	65.00
66.00	06600	PHYSICAL THERAPY	223,272	2,785,016	0.080169	127,422	10,215	66.00
69.00	06900	ELECTROCARDIOLOGY	49,906	6,825,538	0.007312	6,075	44	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	461,633	6,685,050	0.069055	18,947	1,308	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	148,431	4,790,010	0.030988	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	638,389	44,026,805	0.014500	367,060	5,322	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	290	77,577	0.003738	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	77,115	882,138	0.087418	0	0	90.00
91.00	09100	EMERGENCY	1,118,914	29,853,641	0.037480	11,451	429	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,902,654	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	5,384,678	194,518,046		1,080,880	29,789	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Subprovider - IPF | 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		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: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Subprovider - IPF | 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	16,324,750	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	39,266,961	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	3,952,874	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	6,187,480	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,624,933	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	24,003,126	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,329,493	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,785,016	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,825,538	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,685,050	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,790,010	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	44,026,805	0.000000	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	77,577	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	882,138	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	29,853,641	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,902,654	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	194,518,046		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Subprovider - IPF | 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	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	75,806	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	16,731	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	6,850	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	424,608	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	25,930	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	127,422	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	6,075	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	18,947	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	367,060	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	1,240	0	90.00
91.00	09100	EMERGENCY	0.000000	11,451	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,080,880	0	1,240	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Subprovider - IPF | 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	0.213719	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122174	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.068880	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.216802	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.084963	0	0	0	0	56.00
60.00	06000	LABORATORY	0.150146	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.324383	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.415455	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.084977	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297207	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.178042	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266828	0	0	570	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.142761	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.428755	1,240	0	0	532	90.00
91.00	09100	EMERGENCY	0.188004	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.496655	0	0	0	0	92.00
200.00		Subtotal (see instructions)		1,240	0	570	532	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		1,240	0	570	532	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Subprovider - IPF | 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	152		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		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	152		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	152		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 3:23 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.213719	0	0	1,895,935	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122174	0	0	6,245,823	0	54.00
54.01	05401	ULTRASOUND	0.068880	0	0	642,906	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.216802	0	0	2,434,981	0	55.00
56.00	05600	RADIOISOTOPE	0.084963	0	0	226,973	0	56.00
60.00	06000	LABORATORY	0.150146	0	0	4,077,906	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.324383	0	0	274,117	0	65.00
66.00	06600	PHYSICAL THERAPY	0.415455	0	0	466,173	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.084977	0	0	679,630	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297207	0	0	120,849	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.178042	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266828	0	0	1,352,523	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.142761	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.428755	0	0	120,815	0	90.00
91.00	09100	EMERGENCY	0.188004	0	0	8,269,353	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.496655	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	26,807,984	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	26,807,984	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 3:23 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	405,197		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	763,077		54.00
54.01	05401	ULTRASOUND	0	44,283		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	527,909		55.00
56.00	05600	RADIOISOTOPE	0	19,284		56.00
60.00	06000	LABORATORY	0	612,281		60.00
65.00	06500	RESPIRATORY THERAPY	0	88,919		65.00
66.00	06600	PHYSICAL THERAPY	0	193,674		66.00
69.00	06900	ELECTROCARDIOLOGY	0	57,753		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	35,917		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	360,891		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	51,800		90.00
91.00	09100	EMERGENCY	0	1,554,671		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	4,715,656		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	4,715,656		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,074	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,074	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)	2,581	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,462	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,289,027	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,289,027	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,289,027	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)	1,298.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,898,027	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,898,027	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,740,221	450	3,867.16	220	850,775	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,514,433	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,263,235	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)	663,212	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	332,335	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	995,547	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,267,688	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)	1,493	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,298.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,938,272	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,546,785	5,289,027	0.292452	1,938,272	566,852	90.00
91.00	Nursing School cost	0	5,289,027	0.000000	1,938,272	0	91.00
92.00	Allied health cost	0	5,289,027	0.000000	1,938,272	0	92.00
93.00	All other Medical Education	0	5,289,027	0.000000	1,938,272	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0022 Component CCN: 15-S022	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/30/2019 3:23 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,286	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,286	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)	2,286	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,753	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)	2,755,631	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)	2,755,631	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)	2,755,631	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)	1,205.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,113,136	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)	2,113,136	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	242,340	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,355,476	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)	414,760	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	29,789	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	444,549	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,910,927	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0022 Component CCN: 15-S022	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/30/2019 3:23 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	540,876	2,755,631	0.196280	0	0	90.00
91.00	Nursing School cost	0	2,755,631	0.000000	0	0	91.00
92.00	Allied health cost	0	2,755,631	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,755,631	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,248,040		30.00
31.00	03100	INTENSIVE CARE UNIT		943,268		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.213719	1,531,304	327,269	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122174	2,008,269	245,358	54.00
54.01	05401	ULTRASOUND	0.068880	164,690	11,344	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.216802	31,858	6,907	55.00
56.00	05600	RADIOISOTOPE	0.084963	71,955	6,114	56.00
60.00	06000	LABORATORY	0.150146	2,729,785	409,866	60.00
65.00	06500	RESPIRATORY THERAPY	0.324383	1,015,496	329,410	65.00
66.00	06600	PHYSICAL THERAPY	0.415455	204,918	85,134	66.00
69.00	06900	ELECTROCARDIOLOGY	0.084977	530,284	45,062	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297207	106,229	31,572	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.178042	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266828	2,907,760	775,872	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.142761	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.428755	0	0	90.00
91.00	09100	EMERGENCY	0.188004	1,279,361	240,525	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.496655	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		12,581,909	2,514,433	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		12,581,909		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Subprovider - IPF | 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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		3,664,720		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.213719	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122174	75,806	9,262	54.00
54.01	05401	ULTRASOUND	0.068880	16,731	1,152	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.216802	0	0	55.00
56.00	05600	RADIOISOTOPE	0.084963	6,850	582	56.00
60.00	06000	LABORATORY	0.150146	424,608	63,753	60.00
65.00	06500	RESPIRATORY THERAPY	0.324383	25,930	8,411	65.00
66.00	06600	PHYSICAL THERAPY	0.415455	127,422	52,938	66.00
69.00	06900	ELECTROCARDIOLOGY	0.084977	6,075	516	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297207	18,947	5,631	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.178042	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266828	367,060	97,942	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.142761	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.428755	0	0	90.00
91.00	09100	EMERGENCY	0.188004	11,451	2,153	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.496655	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,080,880	242,340	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)		1,080,880		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 3:23 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		356,954		30.00
31.00	03100	INTENSIVE CARE UNIT		205,364		31.00
40.00	04000	SUBPROVIDER - IPF		142,920		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.213719	257,810	55,099	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122174	263,974	32,251	54.00
54.01	05401	ULTRASOUND	0.068880	23,276	1,603	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.216802	0	0	55.00
56.00	05600	RADIOISOTOPE	0.084963	6,060	515	56.00
60.00	06000	LABORATORY	0.150146	452,287	67,909	60.00
65.00	06500	RESPIRATORY THERAPY	0.324383	125,376	40,670	65.00
66.00	06600	PHYSICAL THERAPY	0.415455	10,986	4,564	66.00
69.00	06900	ELECTROCARDIOLOGY	0.084977	77,457	6,582	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297207	19,446	5,779	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.178042	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266828	494,318	131,898	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.142761	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.428755	0	0	90.00
91.00	09100	EMERGENCY	0.188004	203,725	38,301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.496655	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,934,715	385,171	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)		1,934,715		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 3:23 pm

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.213719	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122174	0	0	54.00
54.01	05401	ULTRASOUND	0.068880	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.216802	0	0	55.00
56.00	05600	RADIOISOTOPE	0.084963	0	0	56.00
60.00	06000	LABORATORY	0.150146	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.324383	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.415455	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.084977	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297207	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.178042	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266828	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.142761	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.428755	0	0	90.00
91.00	09100	EMERGENCY	0.188004	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.496655	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 3:23 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	3,010,037	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	683,324	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)	13,149	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)	24.91	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)	0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)	0.00	31.00
32.00	Sum of lines 30 and 31	0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	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)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		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)	3,706,510		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	3,549,516		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	3,706,510	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	310,099	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)	4,016,609	59.00
60.00	Primary payer payments	4,634	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	4,011,975	61.00
62.00	Deductibles billed to program beneficiaries	489,028	62.00
63.00	Coinsurance billed to program beneficiaries	1,675	63.00
64.00	Allowable bad debts (see instructions)	93,604	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	60,843	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	28,067	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	3,582,115	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)	14,399	70.93
70.94	HRR adjustment amount (see instructions)	-29,918	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 3:23 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2018	464,730	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2019	150,640	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		11,924	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,170,042	71.00
71.01	Sequestration adjustment (see instructions)		83,401	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		4,182,614	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)		-95,973	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	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)	1.0035125329	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)	0.9914	0.9941	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: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/30/2019 3:23 pm

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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	3,010,037	0	3,010,037		3,010,037	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	683,324	0		683,324	683,324	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	13,149	0	13,149	0	13,149	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	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	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	3,706,510	0	3,023,186	683,324	3,706,510	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	3,706,510	0	3,023,186	683,324	3,706,510	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	310,099	0	254,501	55,598	310,099	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: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/30/2019 3:23 pm

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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	3,277,687	738,922	4,016,609	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	300,712	0	245,114	55,598	300,712	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	9,387	0	9,387	0	9,387	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	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	310,099	0	254,501	55,598	310,099	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				0.141786	0.203864		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			464,730		464,730	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				150,640	150,640	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2019 3:23 pm

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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	3,010,037	3,010,037		3,010,037	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	683,324		683,324	683,324	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	13,149	13,149	0	13,149	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	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	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	3,706,510	3,023,186	683,324	3,706,510	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	3,706,510	3,023,186	683,324	3,706,510	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	310,099	-48,577	358,676	310,099	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			2,974,609	1,042,000	4,016,609	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	300,712	-55,598	356,310	300,712	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	9,387	7,021	2,366	9,387	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		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	310,099	-48,577	358,676	310,099	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	464,730	464,730		464,730	28.00
29.00	Low volume adjustment on or after October 1	70.97	150,640		150,640	150,640	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	14,399	10,573	3,826	14,399	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	-29,918	-25,886	-4,032	-29,918	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	11,924	11,924	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/30/2019 3:23 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	641	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	10,611,709	2.00
3.00	OPPS payments	8,265,906	3.00
4.00	Outlier payment (see instructions)	33,677	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)	641	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,402	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)	2,402	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)	2,402	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,761	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)	641	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)	8,299,583	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,614,330	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)	6,685,894	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)	6,685,894	30.00
31.00	Primary payer payments	58	31.00
32.00	Subtotal (line 30 minus line 31)	6,685,836	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)	242,796	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	157,817	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	178,139	36.00
37.00	Subtotal (see instructions)	6,843,653	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)	6,843,653	40.00
40.01	Sequestration adjustment (see instructions)	136,873	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	6,551,809	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	154,971	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022 Component CCN: 15-S022	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/30/2019 3:23 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	152	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	532	2.00
3.00	OPPS payments	336	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	152	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	570	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)	570	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)	570	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	418	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)	152	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)	336	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)	0	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)	488	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)	488	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	488	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	488	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)	488	40.00
40.01	Sequestration adjustment (see instructions)	10	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	441	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	37	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,182,614		6,551,809	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,182,614		6,551,809	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		154,971	6.01
6.02	SETTLEMENT TO PROGRAM		95,973		0	6.02
7.00	Total Medicare program liability (see instructions)		4,086,641		6,706,780	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2019 3:23 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,632,386		441	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)		1,632,386		441	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		37	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,632,386		478	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: 15-0022	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/30/2019 3:23 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022 Component CCN: 15-S022	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part II Date/Time Prepared: 5/30/2019 3:23 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,754,383	1.00
2.00	Net IPF PPS Outlier Payments	23,087	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	6.263014	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,777,470	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,777,470	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,777,470	18.00
19.00	Deductibles	107,080	19.00
20.00	Subtotal (line 18 minus line 19)	1,670,390	20.00
21.00	Coinsurance	4,690	21.00
22.00	Subtotal (line 20 minus line 21)	1,665,700	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,665,700	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,665,700	31.00
31.01	Sequestration adjustment (see instructions)	33,314	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,632,386	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	23,087	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2019 3:23 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		4,715,656	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	4,715,656	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	4,715,656	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	1,934,715	26,807,984	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,934,715	26,807,984	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,934,715	26,807,984	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,934,715	22,092,328	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	4,715,656	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	4,715,656	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	4,715,656	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	4,715,656	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	4,715,656	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	4,715,656	40.00
41.00	Interim payments	0	4,715,656	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022 Component CCN: 15-S022	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2019 3:23 pm
	Title XIX	Subprovider - IPF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/30/2019 3:23 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	459	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	10,131,241	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,878,653	0	0	0	6.00
7.00	Inventory	1,309,975	0	0	0	7.00
8.00	Prepaid expenses	329,357	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)	8,892,379	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	970,120	0	0	0	12.00
13.00	Land improvements	3,798,810	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	39,595,706	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	507,273	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	23,422,928	0	0	0	23.00
24.00	Accumulated depreciation	-35,694,523	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	32,600,314	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	41,492,693	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,990,279	0	0	0	37.00
38.00	Salaries, wages, and fees payable	951,917	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	387,356	0	0	0	43.00
44.00	Other current liabilities	184,543	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,514,095	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-3,701,440	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-3,701,440	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	812,655	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	40,680,038				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)	40,680,038	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	41,492,693	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/30/2019 3:23 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		41,911,470		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,377,859				2.00
3.00	Total (sum of line 1 and line 2)		48,289,329		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)		48,289,329		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	EQUITY TRANSFERS	7,609,291		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)		7,609,291		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		40,680,038		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00	EQUITY TRANSFERS		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: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/30/2019 3:23 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,776,782		3,776,782	1.00
2.00	SUBPROVIDER - IPF	4,770,834		4,770,834	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,547,616		8,547,616	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,719,574		1,719,574	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)	1,719,574		1,719,574	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,267,190		10,267,190	17.00
18.00	Ancillary services	21,677,909	138,201,704	159,879,613	18.00
19.00	Outpatient services	2,435,078	32,203,355	34,638,433	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	2,863,039	2,863,039	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	34,380,177	173,268,098	207,648,275	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		52,895,666		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)		52,895,666		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0022 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/30/2019 3:23 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	207,648,275	1.00
2.00	Less contractual allowances and discounts on patients' accounts	149,128,610	2.00
3.00	Net patient revenues (line 1 minus line 2)	58,519,665	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	52,895,666	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,623,999	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	4,653	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	177,472	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	10,255	13.00
14.00	Revenue from meals sold to employees and guests	106,882	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	1,493	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	7,545	21.00
22.00	Rental of hospital space	277,356	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	156,643	24.00
24.01	NON OPERATING REV	11,561	24.01
25.00	Total other income (sum of lines 6-24)	753,860	25.00
26.00	Total (line 5 plus line 25)	6,377,859	26.00
27.00	NON OPERATING REVENUE	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)	6,377,859	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0022	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/30/2019 3:23 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	300,712	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	9,387	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	8.30	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)	310,099	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