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: 15-1331	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/30/2019 5:44 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2019 Time: 5:44 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 HARRISON COUNTY HOSPITAL (15-1331) 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	43,612	-861,877	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-1,693	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	41,919	-861,877	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: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 5:44 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 245 ATWOOD ST.	PO Box:			1.00
2.00	City: CORYDON	State: IN	Zip Code: 47112-	County: HARRISON	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	HARRISON COUNTY HOSPITAL	151331	31140	1	12/15/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HARRISON COUNTY SWING BEDS	15Z331	15999		08/14/2011	N	O	O	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	HARRISON COUNTY HHA	157242	15999		12/23/1992	N	P	N	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)	9		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: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 5:44 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.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	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: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 5:44 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: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 5:44 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			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: 15-1331	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 5:44 pm

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

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	Y	N	Y	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: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 5:44 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	607,713	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.	Y		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.01	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 5:44 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	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)	1	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2018	12/31/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2019 5:44 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			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	04/18/2019	Y	04/04/2018 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

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		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.	N		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.	BKD	BKD	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-581-0435	LVCOSTREPORTS@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1331	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 5:44 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.	BKD		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: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2019 5:44 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	21	7,665	105,312.00	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)		21	7,665	105,312.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	7,776.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	113,088.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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)		25				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: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2019 5:44 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)	1,972	81	4,388			1.00
2.00	HMO and other (see instructions)	372	1,172				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	54	0	54			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	20			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,026	81	4,462			7.00
8.00	INTENSIVE CARE UNIT	158	11	324			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		26	859			13.00
14.00	Total (see instructions)	2,184	118	5,645	0.00	462.11	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	922	0	976	0.00	2.37	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	464.48	27.00
28.00	Observation Bed Days		188	1,103			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

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	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	591	30	1,417	1.00
2.00	HMO and other (see instructions)			88	259		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	591	30	1,417	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-1331 | Component CCN: 15-7242 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-4 | Date/Time Prepared: 5/30/2019 5:44 pm

Home Health Agency I | PPS

		1.00	
0.00	County	HARRISON	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	53.00	0.00	5.00	58.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.55	0.00	0.55	5.00
6.00	Direct Nursing Service		0.72	0.00	0.72	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.57	0.00	0.57	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.53	0.00	0.53	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		31140			20.00
20.01			99915			20.01

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	291	56	20	59	426	21.00
22.00	Skilled Nursing Visit Charges	35,965	7,000	2,375	7,375	52,715	22.00
23.00	Physical Therapy Visits	187	15	1	14	217	23.00
24.00	Physical Therapy Visit Charges	26,622	2,250	132	1,986	30,990	24.00
25.00	Occupational Therapy Visits	0	0	0	2	2	25.00
26.00	Occupational Therapy Visit Charges	0	0	0	267	267	26.00
27.00	Speech Pathology Visits	0	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	0	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	163	67	0	47	277	31.00
32.00	Home Health Aide Visit Charges	8,965	3,685	0	2,585	15,235	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	641	138	21	122	922	33.00
34.00	Other Charges	6,581	309	122	840	7,852	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	78,133	13,244	2,629	13,053	107,059	35.00
36.00	Total Number of Episodes (standard/non outlier)	45		10	6	61	36.00
37.00	Total Number of Outlier Episodes		4		0	4	37.00
38.00	Total Non-Routine Medical Supply Charges	915	247	1,771	768	3,701	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/30/2019 5:44 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)	0.238128	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,147,930	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	-514,704	5.00
6.00	Medicaid charges	33,992,489	6.00
7.00	Medicaid cost (line 1 times line 6)	8,094,563	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)	1,461,337	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)	1,461,337	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)	321,480	885,810	1,207,290	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	76,553	885,810	962,363	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)	76,553	885,810	962,363	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)	7,537,319	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	597,783	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	919,665	27.01
28.00	Non-Medicare bad debt expense (see instructions)	6,617,654	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,897,731	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,860,094	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,321,431	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/30/2019 5:44 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		1,529,216	1,529,216	276,254	1,805,470	1.00
1.01	00101	MOB		657,327	657,327	0	657,327	1.01
1.02	00102	AMB DEPR		0	0	64,894	64,894	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,160,867	1,160,867	0	1,160,867	2.00
2.01	00201	AMB EQUIP		0	0	171,131	171,131	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	213,900	1,110,666	1,324,566	6,017,853	7,342,419	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	1,563,579	4,880,438	6,444,017	-437,497	6,006,520	5.01
5.02	00570	ADMITTING	482,682	174,020	656,702	-127,232	529,470	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	425,523	790,822	1,216,345	-120,823	1,095,522	5.03
7.00	00700	OPERATION OF PLANT	254,001	1,368,750	1,622,751	-92,831	1,529,920	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	25,464	250,658	276,122	-9,603	266,519	8.00
9.00	00900	HOUSEKEEPING	510,270	306,524	816,794	-111,519	705,275	9.00
10.00	01000	DIETARY	396,755	453,707	850,462	-488,633	361,829	10.00
11.00	01100	CAFETERIA	0	0	0	388,116	388,116	11.00
13.00	01300	NURSING ADMINISTRATION	621,159	187,037	808,196	-136,167	672,029	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	240,784	2,229,912	2,470,696	-1,717,230	753,466	14.00
15.00	01500	PHARMACY	365,525	1,981,828	2,347,353	-1,625,287	722,066	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	594,803	260,201	855,004	-176,750	678,254	16.00
17.00	01700	SOCIAL SERVICE	298,973	77,316	376,289	-49,242	327,047	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,147,497	866,594	4,014,091	-1,292,587	2,721,504	30.00
31.00	03100	INTENSIVE CARE UNIT	435,690	119,004	554,694	-93,435	461,259	31.00
43.00	04300	NURSERY	0	130	130	346,951	347,081	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	993,746	698,908	1,692,654	-458,518	1,234,136	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	215,716	215,716	52.00
53.00	05300	ANESTHESIOLOGY	-618	1,105,218	1,104,600	-15,504	1,089,096	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,122,079	1,166,845	2,288,924	-357,042	1,931,882	54.00
60.00	06000	LABORATORY	801,763	1,641,055	2,442,818	-448,125	1,994,693	60.00
65.00	06500	RESPIRATORY THERAPY	0	538,326	538,326	-85,489	452,837	65.00
66.00	06600	PHYSICAL THERAPY	292,848	93,128	385,976	-100,853	285,123	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	39,419	39,419	1,678	41,097	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	14,171	14,171	68.00
69.00	06900	ELECTROCARDIOLOGY	526,016	197,758	723,774	-34,149	689,625	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,144,069	1,144,069	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,002,367	1,002,367	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,555,203	1,555,203	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	19,562	83,439	103,001	-34,225	68,776	90.00
90.01	09001	SENIOR CARE	129,693	172,535	302,228	-20,104	282,124	90.01
91.00	09100	EMERGENCY	1,667,831	809,260	2,477,091	-349,942	2,127,149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,108,214	1,572,829	3,681,043	-861,914	2,819,129	95.00
101.00	10100	HOME HEALTH AGENCY	144,384	78,190	222,574	-23,448	199,126	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		221,921	221,921	-221,921	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,382,123	26,823,848	44,205,971	1,708,333	45,914,304	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	8,845,691	4,639,092	13,484,783	-1,543,855	11,940,928	192.00
194.00	07950	MARKETING	67,102	329,188	396,290	-30,057	366,233	194.00
194.01	07951	PHYSICIAN BILLING	561,609	205,231	766,840	-134,421	632,419	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	26,856,525	31,997,359	58,853,884	0	58,853,884	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/30/2019 5:44 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	-26,413	1,779,057		1.00
1.01	00101	MOB	0	657,327		1.01
1.02	00102	AMB DEPR	0	64,894		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-460	1,160,407		2.00
2.01	00201	AMB EQUIP	0	171,131		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,342,419		4.00
5.01	00590	ADMINISTRATIVE & GENERAL	-1,404,195	4,602,325		5.01
5.02	00570	ADMITTING	0	529,470		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,095,522		5.03
7.00	00700	OPERATION OF PLANT	0	1,529,920		7.00
7.01	00701	AMB PLANT OPS	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	266,519		8.00
9.00	00900	HOUSEKEEPING	0	705,275		9.00
10.00	01000	DIETARY	0	361,829		10.00
11.00	01100	CAFETERIA	-134,956	253,160		11.00
13.00	01300	NURSING ADMINISTRATION	-8,500	663,529		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	753,466		14.00
15.00	01500	PHARMACY	0	722,066		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-25,286	652,968		16.00
17.00	01700	SOCIAL SERVICE	0	327,047		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,721,504		30.00
31.00	03100	INTENSIVE CARE UNIT	0	461,259		31.00
43.00	04300	NURSERY	0	347,081		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,234,136		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	215,716		52.00
53.00	05300	ANESTHESIOLOGY	-1,072,382	16,714		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,931,882		54.00
60.00	06000	LABORATORY	-660	1,994,033		60.00
65.00	06500	RESPIRATORY THERAPY	0	452,837		65.00
66.00	06600	PHYSICAL THERAPY	0	285,123		66.00
67.00	06700	OCCUPATIONAL THERAPY	-182	40,915		67.00
68.00	06800	SPEECH PATHOLOGY	0	14,171		68.00
69.00	06900	ELECTROCARDIOLOGY	0	689,625		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,144,069		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,002,367		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,555,203		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	68,776		90.00
90.01	09001	SENIOR CARE	0	282,124		90.01
91.00	09100	EMERGENCY	0	2,127,149		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-24,759	2,794,370		95.00
101.00	10100	HOME HEALTH AGENCY	0	199,126		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,697,793	43,216,511		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	11,940,928		192.00
194.00	07950	MARKETING	0	366,233		194.00
194.01	07951	PHYSICIAN BILLING	0	632,419		194.01
194.02	07952	MOB	0	0		194.02
194.03	07953	FOUNDATION	0	0		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,697,793	56,156,091		200.00

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 5:44 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,017,853		1.00
2.00	ANESTHESIOLOGY	53.00	0	164		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
	0		0	6,018,017		
	B - EKG					
1.00	ELECTROCARDIOLOGY	69.00	44,273	55,011		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
	0		44,273	55,011		
	C - LDRP					
1.00	NURSERY	43.00	328,325	18,642		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	204,126	11,590		2.00
	0		532,451	30,232		
	D - CAFETERIA					
1.00	CAFETERIA	11.00	205,331	182,785		1.00
	0		205,331	182,785		
	E - THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	1,013	665		1.00
2.00	SPEECH PATHOLOGY	68.00	14,072	99		2.00
	0		15,085	764		
	F - AMBULANCE CAPITAL					
1.00	AMB DEPR	1.02	0	64,894		1.00
2.00	AMB EQUIP	2.01	0	171,131		2.00
	0		0	236,025		
	G - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,382,461		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
	0		0	2,382,461		
	H - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,555,203		1.00
	0		0	1,555,203		
	I - CAPITAL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	221,921		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	54,333		2.00
	0		0	276,254		

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 5:44 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	J - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,002,367		1.00
	TOTALS		0	1,002,367		
	K - ANESTHESIA SALARY					
1.00	ANESTHESIOLOGY	53.00	618	0		1.00
	TOTALS		618	0		
500.00	Grand Total: Increases		797,758	11,739,119		500.00

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 5:44 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.01	0	383,164	0		1.00
2.00	ADMITTING	5.02	0	127,232	0		2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	120,823	0		3.00
4.00	OPERATION OF PLANT	7.00	0	92,831	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	9,603	0		5.00
6.00	HOUSEKEEPING	9.00	0	111,519	0		6.00
7.00	DIETARY	10.00	0	100,517	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	136,167	0		8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	46,904	0		9.00
10.00	PHARMACY	15.00	0	68,900	0		10.00
11.00	MEDICAL RECORDS & LIBRARY	16.00	0	176,750	0		11.00
12.00	SOCIAL SERVICE	17.00	0	49,242	0		12.00
13.00	ADULTS & PEDIATRICS	30.00	0	707,659	0		13.00
14.00	INTENSIVE CARE UNIT	31.00	0	91,846	0		14.00
15.00	OPERATING ROOM	50.00	0	262,585	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	258,030	0		16.00
17.00	LABORATORY	60.00	0	189,783	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	85,004	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	106,753	0		19.00
20.00	CLINIC	90.00	0	1,495	0		20.00
21.00	SENIOR CARE	90.01	0	20,104	0		21.00
22.00	EMERGENCY	91.00	0	340,065	0		22.00
23.00	AMBULANCE SERVICES	95.00	0	799,260	0		23.00
24.00	HOME HEALTH AGENCY	101.00	0	23,448	0		24.00
25.00	PHYSICIANS PRIVATE OFFICES	192.00	0	1,543,855	0		25.00
26.00	MARKETING	194.00	0	30,057	0		26.00
27.00	PHYSICIAN BILLING	194.01	0	134,421	0		27.00
	0		0	6,018,017			
	B - EKG						
1.00	INTENSIVE CARE UNIT	31.00	17	0	0		1.00
2.00	LABORATORY	60.00	40,615	0	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	55,011	0		3.00
4.00	EMERGENCY	91.00	3,641	0	0		4.00
	0		44,273	55,011			
	C - LDRP						
1.00	ADULTS & PEDIATRICS	30.00	532,451	30,232	0		1.00
2.00		0.00	0	0	0		2.00
	0		532,451	30,232			
	D - CAFETERIA						
1.00	DIETARY	10.00	205,331	182,785	0		1.00
	0		205,331	182,785			
	E - THERAPY						
1.00	PHYSICAL THERAPY	66.00	15,085	764	0		1.00
2.00		0.00	0	0	0		2.00
	0		15,085	764			
	F - AMBULANCE CAPITAL						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	236,025	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	236,025			
	G - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,670,326	0		1.00
2.00	PHARMACY	15.00	0	1,184	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	22,245	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	1,572	0		4.00
5.00	NURSERY	43.00	0	16	0		5.00
6.00	OPERATING ROOM	50.00	0	195,933	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	15,668	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	99,012	0		8.00
9.00	LABORATORY	60.00	0	217,727	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	30,478	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	26,680	0		11.00
12.00	CLINIC	90.00	0	32,730	0		12.00
13.00	EMERGENCY	91.00	0	6,236	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	62,654	0		14.00
	0		0	2,382,461			
	H - DRUGS						
1.00	PHARMACY	15.00	0	1,555,203	0		1.00
	0		0	1,555,203			

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 5:44 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	I - CAPITAL						
1.00	ADMINISTRATIVE & GENERAL	5.01	0	54,333	11		1.00
2.00	INTEREST EXPENSE	113.00	0	221,921	12		2.00
	0		0	276,254			
	J - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,002,367	0		1.00
	TOTALS		0	1,002,367			
	K - ANESTHESIA SALARY						
1.00	ANESTHESIOLOGY	53.00	0	618	0		1.00
	TOTALS		0	618			
500.00	Grand Total: Decreases		797,140	11,739,737			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2019 5:44 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,001,138	0	0	0	0	1.00
2.00	Land Improvements	3,379,433	0	0	0	0	2.00
3.00	Buildings and Fixtures	40,406,678	842,583	0	842,583	0	3.00
4.00	Building Improvements	4,309,403	0	0	0	704,268	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	28,124,986	0	0	0	744,750	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	79,221,638	842,583	0	842,583	1,449,018	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	79,221,638	842,583	0	842,583	1,449,018	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,001,138	0	1.00
2.00	Land Improvements	3,379,433	0	2.00
3.00	Buildings and Fixtures	41,249,261	0	3.00
4.00	Building Improvements	3,605,135	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	27,380,236	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	78,615,203	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	78,615,203	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2019 5:44 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	1,529,216	0	0	0	0	1.00
1.01	MOB	275,756	74,035	115,435	13,725	0	1.01
1.02	AMB DEPR	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	1,160,867	0	0	0	0	2.00
2.01	AMB EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,965,839	74,035	115,435	13,725	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	1,529,216		1.00
1.01	MOB	178,376	657,327		1.01
1.02	AMB DEPR	0	0		1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,160,867		2.00
2.01	AMB EQUIP	0	0		2.01
3.00	Total (sum of lines 1-2)	178,376	3,347,410		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III | Date/Time Prepared: 5/30/2019 5:44 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	43,690,436	0	43,690,436	0.555750	0	1.00
1.01	MOB	7,544,531	0	7,544,531	0.095968	0	1.01
1.02	AMB DEPR	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	27,380,236	0	27,380,236	0.348282	0	2.00
2.01	AMB EQUIP	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	78,615,203	0	78,615,203	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	1,519,989	0	1.00
1.01	MOB	0	0	0	275,756	74,035	1.01
1.02	AMB DEPR	0	0	0	64,894	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,160,407	0	2.00
2.01	AMB EQUIP	0	0	0	171,131	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	3,192,177	74,035	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	204,735	54,333	0	0	1,779,057	1.00
1.01	MOB	115,435	13,725	0	178,376	657,327	1.01
1.02	AMB DEPR	0	0	0	0	64,894	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,160,407	2.00
2.01	AMB EQUIP	0	0	0	0	171,131	2.01
3.00	Total (sum of lines 1-2)	320,170	68,058	0	178,376	3,832,816	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/30/2019 5:44 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	-17,186	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - MOB (chapter 2)		0	MOB	1.01	0	1.01
1.02	Investment income - AMB DEPR (chapter 2)		0	AMB DEPR	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - AMB EQUIP (chapter 2)		0	AMB EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,355	ADMINISTRATIVE & GENERAL	5.01	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-19,882			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-134,956	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-25,286	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	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
26.01	Depreciation - MOB		0	MOB	1.01	0	26.01
26.02	Depreciation - AMB DEPR		0	AMB DEPR	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - AMB EQUIP		0	AMB EQUIP	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/30/2019 5:44 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	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	-182	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC. INCOME - A&G	B	-81,944	ADMINISTRATIVE & GENERAL	5.01	0	33.00
33.01	MISC. INCOME - LAB	B	-660	LABORATORY	60.00	0	33.01
33.02	MISC. INCOME - AMBULANCE	B	-12,759	AMBULANCE SERVICES	95.00	0	33.02
34.00	PATIENT TELEPHONES - DEPRECIATION	A	-460	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.00
34.01	PATIENT TELEPHONES - EXPENSES	A	-7,825	ADMINISTRATIVE & GENERAL	5.01	0	34.01
35.00	CRNA	A	-1,073,000	ANESTHESIOLOGY	53.00	0	35.00
36.00	IHA & AHA DUES	A	-5,403	ADMINISTRATIVE & GENERAL	5.01	0	36.00
37.00	HAF FEES	A	-1,307,668	ADMINISTRATIVE & GENERAL	5.01	0	37.00
38.00	UNECESSARY BORROWING	A	-9,227	CAP REL COSTS-BLDG & FIXT	1.00	9	38.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,697,793				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2019 5:44 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	13.00	NURSING ADMINISTRATION	8,500	8,500	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	-618	-618	0	0	0	2.00
3.00	60.00	LABORATORY	43,335	0	43,335	0	0	3.00
4.00	91.00	EMERGENCY	319,696	0	319,696	0	0	4.00
5.00	95.00	AMBULANCE SERVICES	12,000	12,000	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			382,913	19,882	363,031		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	13.00	NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	95.00	AMBULANCE SERVICES	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	13.00	NURSING ADMINISTRATION	0	0	0	8,500		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	-618		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	95.00	AMBULANCE SERVICES	0	0	0	12,000		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	19,882		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1331	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2019 5:44 pm

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	12,500.80	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	74.96	65.18	48.89	36.66	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	32.59	32.59	24.45			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	814,802	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	814,802	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	814,802	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	814,802	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/30/2019 5:44 pm

		Respiratory Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	65.18	0.00	36.66	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	814,802	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	814,802	63.00
64.00	Total cost of outside supplier services (from your records)	480,899	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/30/2019 5:44 pm

		Occupational Therapy	Cost
		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	26	1.00
2.00	Line 1 multiplied by 15 hours per week	390	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	499.20	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	90.39	78.60	58.95	44.21	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.30	39.30	29.48			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	39,237	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	39,237	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	39,237	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	39,237	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/30/2019 5:44 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.60	58.95	44.21	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	39,237	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	39,237	63.00
64.00	Total cost of outside supplier services (from your records)	39,419	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	182	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 5:44 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	MOB	AMB DEPR	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,779,057	1,779,057				1.00
1.01	00101	MOB	657,327	0	657,327			1.01
1.02	00102	AMB DEPR	64,894	0	0	64,894		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,160,407				1,160,407	2.00
2.01	00201	AMB EQUIP	171,131				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,342,419	2,608	0	0	1,701	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	4,602,325	259,453	3,834	0	169,230	5.01
5.02	00570	ADMITTING	529,470	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,095,522	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	1,529,920	204,568	0	0	133,432	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	266,519	11,944	0	0	7,791	8.00
9.00	00900	HOUSEKEEPING	705,275	25,584	0	0	16,687	9.00
10.00	01000	DIETARY	361,829	74,444	0	0	48,557	10.00
11.00	01100	CAFETERIA	253,160	37,189	0	0	24,257	11.00
13.00	01300	NURSING ADMINISTRATION	663,529	6,259	0	0	4,083	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	753,466	0	0	0	0	14.00
15.00	01500	PHARMACY	722,066	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	652,968	41,532	0	0	27,089	16.00
17.00	01700	SOCIAL SERVICE	327,047	2,504	0	0	1,633	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,721,504	302,563	0	0	197,349	30.00
31.00	03100	INTENSIVE CARE UNIT	461,259	37,776	0	0	24,640	31.00
43.00	04300	NURSERY	347,081	7,824	0	0	5,103	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,234,136	231,091	0	0	150,731	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	215,716	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	16,714	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,931,882	121,074	0	0	78,972	54.00
60.00	06000	LABORATORY	1,994,033	63,634	0	0	41,506	60.00
65.00	06500	RESPIRATORY THERAPY	452,837	13,848	0	0	9,033	65.00
66.00	06600	PHYSICAL THERAPY	285,123	46,852	0	0	30,560	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,915	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,171	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	689,625	23,785	0	0	15,514	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,144,069	56,801	0	0	37,049	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,002,367	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,555,203	15,987	0	0	10,428	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	68,776	0	31,552	0	0	90.00
90.01	09001	SENIOR CARE	282,124	0	22,886	0	0	90.01
91.00	09100	EMERGENCY	2,127,149	85,528	31,552	0	55,786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,794,370	0	0	64,894	0	95.00
101.00	10100	HOME HEALTH AGENCY	199,126	0	9,311	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,216,511	1,672,848	99,135	64,894	1,091,131	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	10,627	0	0	6,932	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	11,940,928	86,271	0	0	56,271	192.00
194.00	07950	MARKETING	366,233	2,791	0	0	1,820	194.00
194.01	07951	PHYSICIAN BILLING	632,419	6,520	0	0	4,253	194.01
194.02	07952	MOB	0	0	558,192	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	56,156,091	1,779,057	657,327	64,894	1,160,407	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 5:44 pm

		Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	ADMITTING	
			2.01	4.00	4A	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP	171,131					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,346,728				4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	431,149	5,465,991	5,465,991		5.01
5.02	00570	ADMITTING	0	133,097	662,567	71,446	734,013	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	117,336	1,212,858	130,785	0	5.03
7.00	00700	OPERATION OF PLANT	0	70,040	1,937,960	208,974	0	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,022	293,276	31,625	0	8.00
9.00	00900	HOUSEKEEPING	0	140,704	888,250	95,782	0	9.00
10.00	01000	DIETARY	0	52,784	537,614	57,972	0	10.00
11.00	01100	CAFETERIA	0	56,619	371,225	40,030	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	171,281	845,152	91,134	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	66,395	819,861	88,407	0	14.00
15.00	01500	PHARMACY	0	100,792	822,858	88,730	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	164,014	885,603	95,496	0	16.00
17.00	01700	SOCIAL SERVICE	0	82,440	413,624	44,602	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	721,086	3,942,502	425,128	48,686	30.00
31.00	03100	INTENSIVE CARE UNIT	0	120,135	643,810	69,423	3,680	31.00
43.00	04300	NURSERY	0	90,534	450,542	48,583	7,126	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	274,020	1,889,978	203,800	52,702	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	56,287	272,003	29,331	4,458	52.00
53.00	05300	ANESTHESIOLOGY	0	0	16,714	1,802	10,678	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	309,408	2,441,336	263,254	179,290	54.00
60.00	06000	LABORATORY	0	209,883	2,309,056	248,990	119,029	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	475,718	51,298	14,306	65.00
66.00	06600	PHYSICAL THERAPY	0	76,592	439,127	47,352	11,222	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	279	41,194	4,442	1,145	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,880	18,051	1,946	262	68.00
69.00	06900	ELECTROCARDIOLOGY	0	157,254	886,178	95,558	47,642	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,237,919	133,487	30,335	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,002,367	108,087	14,649	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,581,618	170,549	38,505	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,394	105,722	11,400	1,043	90.00
90.01	09001	SENIOR CARE	0	35,762	340,772	36,746	3,514	90.01
91.00	09100	EMERGENCY	0	458,892	2,758,907	297,498	102,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	171,131	581,329	3,611,724	389,459	42,806	95.00
101.00	10100	HOME HEALTH AGENCY	0	39,813	248,250	26,769	847	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	171,131	4,734,221	39,870,327	3,709,885	734,013	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	17,559	1,893	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	2,439,143	14,522,613	1,565,982	0	192.00
194.00	07950	MARKETING	0	18,503	389,347	41,984	0	194.00
194.01	07951	PHYSICIAN BILLING	0	154,861	798,053	86,056	0	194.01
194.02	07952	MOB	0	0	558,192	60,191	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments			0	0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	171,131	7,346,728	56,156,091	5,465,991	734,013	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 5:44 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OPERATION OF PLANT	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.03	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,343,643					5.03
7.00	00700	OPERATION OF PLANT	0	2,146,934				7.00
7.01	00701	AMB PLANT OPS	0	0	0			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,539	0	344,440		8.00
9.00	00900	HOUSEKEEPING	0	41,852	0	25	1,025,909	9.00
10.00	01000	DIETARY	0	121,779	0	5,422	59,905	10.00
11.00	01100	CAFETERIA	0	60,836	0	0	29,926	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,239	0	0	5,037	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	67,940	0	0	33,420	16.00
17.00	01700	SOCIAL SERVICE	0	4,096	0	0	2,015	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	89,130	494,944	0	152,715	243,471	30.00
31.00	03100	INTENSIVE CARE UNIT	6,738	61,796	0	0	30,398	31.00
43.00	04300	NURSERY	13,046	12,799	0	0	6,296	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	96,483	378,030	0	23,992	185,958	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,162	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	19,549	0	0	32	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	328,106	198,059	0	44,483	97,428	54.00
60.00	06000	LABORATORY	217,908	104,096	0	0	51,206	60.00
65.00	06500	RESPIRATORY THERAPY	26,189	22,654	0	523	11,144	65.00
66.00	06600	PHYSICAL THERAPY	20,544	76,643	0	5,353	37,702	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,097	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	479	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	87,220	38,908	0	517	19,139	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	55,535	92,918	0	0	45,708	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,817	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,491	26,152	0	0	12,865	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,909	0	0	2,207	0	90.00
90.01	09001	SENIOR CARE	6,432	0	0	108	0	90.01
91.00	09100	EMERGENCY	186,893	139,911	0	83,449	68,824	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	78,365	0	0	14,787	0	95.00
101.00	10100	HOME HEALTH AGENCY	1,550	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,343,643	1,973,191	0	333,613	940,442	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	17,385	0	0	8,552	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	141,127	0	10,827	69,422	192.00
194.00	07950	MARKETING	0	4,565	0	0	2,246	194.00
194.01	07951	PHYSICIAN BILLING	0	10,666	0	0	5,247	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	1,343,643	2,146,934	0	344,440	1,025,909	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 5:44 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	782,692					10.00
11.00	01100	CAFETERIA	0	502,017				11.00
13.00	01300	NURSING ADMINISTRATION	0	14,737	966,299			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,372	0	920,640		14.00
15.00	01500	PHARMACY	0	6,345	0	1,602	919,535	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,527	0	4,665	0	16.00
17.00	01700	SOCIAL SERVICE	0	7,347	0	330	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	729,706	84,589	390,624	20,223	0	30.00
31.00	03100	INTENSIVE CARE UNIT	52,986	9,770	45,115	5,585	0	31.00
43.00	04300	NURSERY	0	9,361	43,227	29	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	27,086	125,079	28,837	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,820	26,875	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	26	0	2,472	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,288	0	39,119	0	54.00
60.00	06000	LABORATORY	0	26,350	0	179,400	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,391	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,975	0	1,278	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,294	79,861	3,610	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	346,772	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	251,861	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	919,535	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	575	2,655	321	0	90.00
90.01	09001	SENIOR CARE	0	3,864	17,844	367	0	90.01
91.00	09100	EMERGENCY	0	50,893	235,019	16,833	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	14,945	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	782,692	349,219	966,299	920,640	919,535	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	126,680	0	0	0	192.00
194.00	07950	MARKETING	0	1,718	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	24,400	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	782,692	502,017	966,299	920,640	919,535	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 5:44 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,114,651					16.00
17.00	01700	SOCIAL SERVICE	0	472,014				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	73,938	440,060	7,135,716	0	7,135,716	30.00
31.00	03100	INTENSIVE CARE UNIT	5,589	31,954	966,844	0	966,844	31.00
43.00	04300	NURSERY	10,822	0	601,831	0	601,831	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	80,037	0	3,091,982	0	3,091,982	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,770	0	353,419	0	353,419	52.00
53.00	05300	ANESTHESIOLOGY	16,216	0	67,489	0	67,489	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	272,220	0	3,900,583	0	3,900,583	54.00
60.00	06000	LABORATORY	180,764	0	3,436,799	0	3,436,799	60.00
65.00	06500	RESPIRATORY THERAPY	21,725	0	625,948	0	625,948	65.00
66.00	06600	PHYSICAL THERAPY	17,042	0	664,238	0	664,238	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,740	0	50,618	0	50,618	67.00
68.00	06800	SPEECH PATHOLOGY	397	0	21,135	0	21,135	68.00
69.00	06900	ELECTROCARDIOLOGY	72,352	0	1,348,279	0	1,348,279	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,068	0	1,988,742	0	1,988,742	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,246	0	1,426,027	0	1,426,027	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,476	0	2,878,191	0	2,878,191	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,584	0	127,416	0	127,416	90.00
90.01	09001	SENIOR CARE	5,336	0	414,983	0	414,983	90.01
91.00	09100	EMERGENCY	155,036	0	4,095,351	0	4,095,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	65,007	0	4,217,093	0	4,217,093	95.00
101.00	10100	HOME HEALTH AGENCY	1,286	0	278,702	0	278,702	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,114,651	472,014	37,691,386	0	37,691,386	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	45,389	0	45,389	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	16,436,651	0	16,436,651	192.00
194.00	07950	MARKETING	0	0	439,860	0	439,860	194.00
194.01	07951	PHYSICIAN BILLING	0	0	924,422	0	924,422	194.01
194.02	07952	MOB	0	0	618,383	0	618,383	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,114,651	472,014	56,156,091	0	56,156,091	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 5:44 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MOB	AMB DEPR	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,608	0	0	1,701	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	259,453	3,834	0	169,230	5.01
5.02	00570	ADMITTING	0	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	0	204,568	0	0	133,432	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,944	0	0	7,791	8.00
9.00	00900	HOUSEKEEPING	0	25,584	0	0	16,687	9.00
10.00	01000	DIETARY	0	74,444	0	0	48,557	10.00
11.00	01100	CAFETERIA	0	37,189	0	0	24,257	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,259	0	0	4,083	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	41,532	0	0	27,089	16.00
17.00	01700	SOCIAL SERVICE	0	2,504	0	0	1,633	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	302,563	0	0	197,349	30.00
31.00	03100	INTENSIVE CARE UNIT	0	37,776	0	0	24,640	31.00
43.00	04300	NURSERY	0	7,824	0	0	5,103	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	231,091	0	0	150,731	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,757	121,074	0	0	78,972	54.00
60.00	06000	LABORATORY	0	63,634	0	0	41,506	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,848	0	0	9,033	65.00
66.00	06600	PHYSICAL THERAPY	3,607	46,852	0	0	30,560	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	23,785	0	0	15,514	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	56,801	0	0	37,049	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	15,987	0	0	10,428	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	47,639	0	31,552	0	0	90.00
90.01	09001	SENIOR CARE	20,536	0	22,886	0	0	90.01
91.00	09100	EMERGENCY	77,054	85,528	31,552	0	55,786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	64,894	0	95.00
101.00	10100	HOME HEALTH AGENCY	10,818	0	9,311	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	200,411	1,672,848	99,135	64,894	1,091,131	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	10,627	0	0	6,932	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	921,523	86,271	0	0	56,271	192.00
194.00	07950	MARKETING	0	2,791	0	0	1,820	194.00
194.01	07951	PHYSICIAN BILLING	0	6,520	0	0	4,253	194.01
194.02	07952	MOB	0	0	558,192	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,121,934	1,779,057	657,327	64,894	1,160,407	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 5:44 pm

		Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	ADMITTING	
			2.01	2A	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,309	4,309			4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	432,517	253	432,770		5.01
5.02	00570	ADMITTING	0	0	78	5,657	5,735	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	69	10,355	0	5.03
7.00	00700	OPERATION OF PLANT	0	338,000	41	16,546	0	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,735	4	2,504	0	8.00
9.00	00900	HOUSEKEEPING	0	42,271	83	7,584	0	9.00
10.00	01000	DIETARY	0	123,001	31	4,590	0	10.00
11.00	01100	CAFETERIA	0	61,446	33	3,170	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,342	101	7,216	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	39	7,000	0	14.00
15.00	01500	PHARMACY	0	0	59	7,026	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	68,621	96	7,561	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,137	48	3,532	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	499,912	424	33,661	378	30.00
31.00	03100	INTENSIVE CARE UNIT	0	62,416	71	5,497	29	31.00
43.00	04300	NURSERY	0	12,927	53	3,847	55	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	381,822	161	16,137	409	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	33	2,322	35	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	143	83	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	240,803	182	20,844	1,427	54.00
60.00	06000	LABORATORY	0	105,140	123	19,715	924	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,881	0	4,062	111	65.00
66.00	06600	PHYSICAL THERAPY	0	81,019	45	3,749	87	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	352	9	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	2	154	2	68.00
69.00	06900	ELECTROCARDIOLOGY	0	39,299	92	7,566	370	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	93,850	0	10,569	236	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,558	114	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	26,415	0	13,504	299	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	79,191	3	903	8	90.00
90.01	09001	SENIOR CARE	0	43,422	21	2,910	27	90.01
91.00	09100	EMERGENCY	0	249,920	270	23,556	793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	171,131	236,025	342	30,837	332	95.00
101.00	10100	HOME HEALTH AGENCY	0	20,129	23	2,120	7	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	171,131	3,299,550	2,780	293,747	5,735	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	17,559	0	150	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	1,064,065	1,427	123,969	0	192.00
194.00	07950	MARKETING	0	4,611	11	3,324	0	194.00
194.01	07951	PHYSICIAN BILLING	0	10,773	91	6,814	0	194.01
194.02	07952	MOB	0	558,192	0	4,766	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	171,131	4,954,750	4,309	432,770	5,735	202.00

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		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OPERATION OF PLANT	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.03	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	10,424					5.03
7.00	00700	OPERATION OF PLANT	0	354,587				7.00
7.01	00701	AMB PLANT OPS	0	0	0			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,227	0	25,470		8.00
9.00	00900	HOUSEKEEPING	0	6,912	0	2	56,852	9.00
10.00	01000	DIETARY	0	20,113	0	401	3,320	10.00
11.00	01100	CAFETERIA	0	10,048	0	0	1,658	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,691	0	0	279	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,221	0	0	1,852	16.00
17.00	01700	SOCIAL SERVICE	0	676	0	0	112	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	693	81,748	0	11,293	13,491	30.00
31.00	03100	INTENSIVE CARE UNIT	52	10,206	0	0	1,685	31.00
43.00	04300	NURSERY	101	2,114	0	0	349	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	750	62,435	0	1,774	10,305	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	63	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	152	0	0	2	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,530	32,711	0	3,289	5,399	54.00
60.00	06000	LABORATORY	1,694	17,192	0	0	2,838	60.00
65.00	06500	RESPIRATORY THERAPY	204	3,741	0	39	618	65.00
66.00	06600	PHYSICAL THERAPY	160	12,658	0	396	2,089	66.00
67.00	06700	OCCUPATIONAL THERAPY	16	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	678	6,426	0	38	1,061	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	432	15,346	0	0	2,533	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	208	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	548	4,319	0	0	713	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15	0	0	163	0	90.00
90.01	09001	SENIOR CARE	50	0	0	8	0	90.01
91.00	09100	EMERGENCY	1,453	23,108	0	6,171	3,814	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	609	0	0	1,093	0	95.00
101.00	10100	HOME HEALTH AGENCY	12	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,424	325,892	0	24,669	52,116	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	2,871	0	0	474	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	23,308	0	801	3,847	192.00
194.00	07950	MARKETING	0	754	0	0	124	194.00
194.01	07951	PHYSICIAN BILLING	0	1,762	0	0	291	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	10,424	354,587	0	25,470	56,852	202.00

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		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	151,456					10.00
11.00	01100	CAFETERIA	0	76,355				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,242	21,871			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,882	0	8,921		14.00
15.00	01500	PHARMACY	0	965	0	16	8,066	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,187	0	45	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,117	0	3	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	141,203	12,866	8,842	196	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,253	1,486	1,021	54	0	31.00
43.00	04300	NURSERY	0	1,424	978	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,120	2,831	279	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	885	608	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	4	0	24	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,671	0	379	0	54.00
60.00	06000	LABORATORY	0	4,008	0	1,739	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	23	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,213	0	12	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,630	1,808	35	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,360	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,441	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	8,066	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	87	60	3	0	90.00
90.01	09001	SENIOR CARE	0	588	404	4	0	90.01
91.00	09100	EMERGENCY	0	7,741	5,319	163	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	145	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	151,456	53,116	21,871	8,921	8,066	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	19,267	0	0	0	192.00
194.00	07950	MARKETING	0	261	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	3,711	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	151,456	76,355	21,871	8,921	8,066	202.00

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		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
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	93,583					16.00
17.00	01700	SOCIAL SERVICE	0	9,625				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,205	8,973	819,885	0	819,885	30.00
31.00	03100	INTENSIVE CARE UNIT	469	652	93,891	0	93,891	31.00
43.00	04300	NURSERY	908	0	22,756	0	22,756	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,717	0	487,740	0	487,740	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	568	0	4,514	0	4,514	52.00
53.00	05300	ANESTHESIOLOGY	1,361	0	1,769	0	1,769	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,883	0	336,118	0	336,118	54.00
60.00	06000	LABORATORY	15,171	0	168,544	0	168,544	60.00
65.00	06500	RESPIRATORY THERAPY	1,823	0	33,502	0	33,502	65.00
66.00	06600	PHYSICAL THERAPY	1,430	0	102,858	0	102,858	66.00
67.00	06700	OCCUPATIONAL THERAPY	146	0	523	0	523	67.00
68.00	06800	SPEECH PATHOLOGY	33	0	195	0	195	68.00
69.00	06900	ELECTROCARDIOLOGY	6,072	0	66,075	0	66,075	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,866	0	130,192	0	130,192	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,867	0	13,188	0	13,188	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,908	0	58,772	0	58,772	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	133	0	80,566	0	80,566	90.00
90.01	09001	SENIOR CARE	448	0	47,882	0	47,882	90.01
91.00	09100	EMERGENCY	13,011	0	335,319	0	335,319	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,456	0	274,839	0	274,839	95.00
101.00	10100	HOME HEALTH AGENCY	108	0	22,399	0	22,399	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,583	9,625	3,101,527	0	3,101,527	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	21,054	0	21,054	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	1,236,684	0	1,236,684	192.00
194.00	07950	MARKETING	0	0	9,085	0	9,085	194.00
194.01	07951	PHYSICIAN BILLING	0	0	23,442	0	23,442	194.01
194.02	07952	MOB	0	0	562,958	0	562,958	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	93,583	9,625	4,954,750	0	4,954,750	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 5:44 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQ UARE FEET)	MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQ UARE FEET)	
			1.00	1.01	1.02	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	136,433					1.00
1.01	00101	MOB	0	33,604				1.01
1.02	00102	AMB DEPR	0	0	11,032			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				136,433		2.00
2.01	00201	AMB EQUIP				0	11,032	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	200	0	0	200	0	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	19,897	196	0	19,897	0	5.01
5.02	00570	ADMITTING	0	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	15,688	0	0	15,688	0	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	916	0	0	916	0	8.00
9.00	00900	HOUSEKEEPING	1,962	0	0	1,962	0	9.00
10.00	01000	DIETARY	5,709	0	0	5,709	0	10.00
11.00	01100	CAFETERIA	2,852	0	0	2,852	0	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	0	480	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	0	3,185	0	16.00
17.00	01700	SOCIAL SERVICE	192	0	0	192	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,203	0	0	23,203	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	0	0	2,897	0	31.00
43.00	04300	NURSERY	600	0	0	600	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,722	0	0	17,722	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	0	0	9,285	0	54.00
60.00	06000	LABORATORY	4,880	0	0	4,880	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	0	1,062	0	65.00
66.00	06600	PHYSICAL THERAPY	3,593	0	0	3,593	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	0	0	1,824	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,356	0	0	4,356	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	1,226	0	0	1,226	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,613	0	0	0	90.00
90.01	09001	SENIOR CARE	0	1,170	0	0	0	90.01
91.00	09100	EMERGENCY	6,559	1,613	0	6,559	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	11,032	0	11,032	95.00
101.00	10100	HOME HEALTH AGENCY	0	476	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,288	5,068	11,032	128,288	11,032	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	815	0	0	815	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	6,616	0	0	6,616	0	192.00
194.00	07950	MARKETING	214	0	0	214	0	194.00
194.01	07951	PHYSICIAN BILLING	500	0	0	500	0	194.01
194.02	07952	MOB	0	28,536	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	1,779,057	657,327	64,894	1,160,407	171,131	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.039785	19.560975	5.882342	8.505325	15.512237	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 5:44 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			4.00	5A.01	5.01	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	26,643,243					4.00
5.01	00590	ADMINISTRATIVE & GENERAL	1,563,579	-5,465,991	50,690,100			5.01
5.02	00570	ADMITTING	482,682	0	662,567	158,281,966		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	425,523	0	1,212,858	0	158,281,966	5.03
7.00	00700	OPERATION OF PLANT	254,001	0	1,937,960	0	0	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	25,464	0	293,276	0	0	8.00
9.00	00900	HOUSEKEEPING	510,270	0	888,250	0	0	9.00
10.00	01000	DIETARY	191,424	0	537,614	0	0	10.00
11.00	01100	CAFETERIA	205,331	0	371,225	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	621,159	0	845,152	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	240,784	0	819,861	0	0	14.00
15.00	01500	PHARMACY	365,525	0	822,858	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	594,803	0	885,603	0	0	16.00
17.00	01700	SOCIAL SERVICE	298,973	0	413,624	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,615,046	0	3,942,502	10,499,505	10,499,505	30.00
31.00	03100	INTENSIVE CARE UNIT	435,673	0	643,810	793,675	793,675	31.00
43.00	04300	NURSERY	328,325	0	450,542	1,536,819	1,536,819	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	993,746	0	1,889,978	11,365,627	11,365,627	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	204,126	0	272,003	961,441	961,441	52.00
53.00	05300	ANESTHESIOLOGY	0	0	16,714	2,302,820	2,302,820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,122,079	0	2,441,336	38,652,429	38,652,429	54.00
60.00	06000	LABORATORY	761,148	0	2,309,056	25,669,418	25,669,418	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	475,718	3,085,078	3,085,078	65.00
66.00	06600	PHYSICAL THERAPY	277,763	0	439,127	2,420,027	2,420,027	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,013	0	41,194	247,021	247,021	67.00
68.00	06800	SPEECH PATHOLOGY	14,072	0	18,051	56,402	56,402	68.00
69.00	06900	ELECTROCARDIOLOGY	570,289	0	886,178	10,274,421	10,274,421	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,237,919	6,541,962	6,541,962	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,002,367	3,159,052	3,159,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,581,618	8,303,845	8,303,845	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	19,562	0	105,722	224,903	224,903	90.00
90.01	09001	SENIOR CARE	129,693	0	340,772	757,714	757,714	90.01
91.00	09100	EMERGENCY	1,664,190	0	2,758,907	22,015,930	22,015,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,108,214	0	3,611,724	9,231,301	9,231,301	95.00
101.00	10100	HOME HEALTH AGENCY	144,384	0	248,250	182,576	182,576	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,168,841	-5,465,991	34,404,336	158,281,966	158,281,966	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	17,559	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	8,845,691	0	14,522,613	0	0	192.00
194.00	07950	MARKETING	67,102	0	389,347	0	0	194.00
194.01	07951	PHYSICIAN BILLING	561,609	0	798,053	0	0	194.01
194.02	07952	MOB	0	0	558,192	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	7,346,728		5,465,991	734,013	1,343,643	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.275745		0.107832	0.004637	0.008489	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,309		432,770	5,735	10,424	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000162		0.008538	0.000036	0.000066	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: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 5:44 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	AMB PLANT OPS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATI ENT DAYS)	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT	100,648					7.00
7.01	00701	AMB PLANT OPS	0	0				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	916	0	223,993			8.00
9.00	00900	HOUSEKEEPING	1,962	0	16	97,770		9.00
10.00	01000	DIETARY	5,709	0	3,526	5,709	4,786	10.00
11.00	01100	CAFETERIA	2,852	0	0	2,852	0	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	0	480	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	0	3,185	0	16.00
17.00	01700	SOCIAL SERVICE	192	0	0	192	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,203	0	99,313	23,203	4,462	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	0	0	2,897	324	31.00
43.00	04300	NURSERY	600	0	0	600	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,722	0	15,602	17,722	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	21	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	0	28,928	9,285	0	54.00
60.00	06000	LABORATORY	4,880	0	0	4,880	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	340	1,062	0	65.00
66.00	06600	PHYSICAL THERAPY	3,593	0	3,481	3,593	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	0	336	1,824	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,356	0	0	4,356	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	1,226	0	0	1,226	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	1,435	0	0	90.00
90.01	09001	SENIOR CARE	0	0	70	0	0	90.01
91.00	09100	EMERGENCY	6,559	0	54,268	6,559	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	9,616	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,503	0	216,952	89,625	4,786	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	815	0	0	815	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	6,616	0	7,041	6,616	0	192.00
194.00	07950	MARKETING	214	0	0	214	0	194.00
194.01	07951	PHYSICIAN BILLING	500	0	0	500	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	2,146,934	0	344,440	1,025,909	782,692	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.331114	0.000000	1.537727	10.493086	163.537819	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	354,587	0	25,470	56,852	151,456	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.523041	0.000000	0.113709	0.581487	31.645633	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: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 5:44 pm

		Cost Center Description	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (TIME SPENT)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	607,635					11.00
13.00	01300	NURSING ADMINISTRATION	17,838	253,273				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,975	0	3,664,002			14.00
15.00	01500	PHARMACY	7,680	0	6,376	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,318	0	18,566	0	158,281,966	16.00
17.00	01700	SOCIAL SERVICE	8,893	0	1,314	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	102,385	102,385	80,484	0	10,499,505	30.00
31.00	03100	INTENSIVE CARE UNIT	11,825	11,825	22,229	0	793,675	31.00
43.00	04300	NURSERY	11,330	11,330	114	0	1,536,819	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,784	32,784	114,766	0	11,365,627	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,044	7,044	0	0	961,441	52.00
53.00	05300	ANESTHESIOLOGY	32	0	9,838	0	2,302,820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,133	0	155,689	0	38,652,429	54.00
60.00	06000	LABORATORY	31,894	0	713,984	0	25,669,418	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	9,517	0	3,085,078	65.00
66.00	06600	PHYSICAL THERAPY	9,653	0	5,087	0	2,420,027	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	247,021	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	56,402	68.00
69.00	06900	ELECTROCARDIOLOGY	20,932	20,932	14,369	0	10,274,421	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,380,094	0	6,541,962	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,002,367	0	3,159,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	8,303,845	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	696	696	1,278	0	224,903	90.00
90.01	09001	SENIOR CARE	4,677	4,677	1,461	0	757,714	90.01
91.00	09100	EMERGENCY	61,600	61,600	66,991	0	22,015,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	59,478	0	9,231,301	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	182,576	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	422,689	253,273	3,664,002	100	158,281,966	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	153,333	0	0	0	0	192.00
194.00	07950	MARKETING	2,080	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	29,533	0	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	502,017	966,299	920,640	919,535	1,114,651	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.826182	3.815247	0.251266	9,195.350000	0.007042	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	76,355	21,871	8,921	8,066	93,583	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.125659	0.086353	0.002435	80.660000	0.000591	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: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 5:44 pm

		Cost Center Description	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	MOB			1.01
1.02	00102	AMB DEPR			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	AMB EQUIP			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00590	ADMINISTRATIVE & GENERAL			5.01
5.02	00570	ADMITTING			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.03
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	AMB PLANT OPS			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	4,786		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	4,462		30.00
31.00	03100	INTENSIVE CARE UNIT	324		31.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
90.01	09001	SENIOR CARE	0		90.01
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,786		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		192.00
194.00	07950	MARKETING	0		194.00
194.01	07951	PHYSICIAN BILLING	0		194.01
194.02	07952	MOB	0		194.02
194.03	07953	FOUNDATION	0		194.03
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)	472,014		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	98.623903		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,625		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.011074		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: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | 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	7,135,716		7,135,716	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	966,844		966,844	0	0	31.00
43.00	04300	NURSERY	601,831		601,831	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,091,982		3,091,982	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	353,419		353,419	0	0	52.00
53.00	05300	ANESTHESIOLOGY	67,489		67,489	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,900,583		3,900,583	0	0	54.00
60.00	06000	LABORATORY	3,436,799		3,436,799	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	625,948	0	625,948	0	0	65.00
66.00	06600	PHYSICAL THERAPY	664,238	0	664,238	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	50,618	0	50,618	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	21,135	0	21,135	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,348,279		1,348,279	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,988,742		1,988,742	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,426,027		1,426,027	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,878,191		2,878,191	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	127,416		127,416	0	0	90.00
90.01	09001	SENIOR CARE	414,983		414,983	0	0	90.01
91.00	09100	EMERGENCY	4,095,351		4,095,351	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,418,789		1,418,789		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,217,093		4,217,093	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	278,702		278,702		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	39,110,175	0	39,110,175	0	0	200.00
201.00		Less Observation Beds	1,418,789		1,418,789		0	201.00
202.00		Total (see instructions)	37,691,386	0	37,691,386	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | 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	6,415,606		6,415,606			30.00
31.00	03100	INTENSIVE CARE UNIT	793,675		793,675			31.00
43.00	04300	NURSERY	1,536,819		1,536,819			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,993,397	8,372,230	11,365,627	0.272047	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	485,715	475,726	961,441	0.367593	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	941,595	1,361,225	2,302,820	0.029307	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,075,210	36,577,219	38,652,429	0.100914	0.000000	54.00
60.00	06000	LABORATORY	3,572,644	22,096,774	25,669,418	0.133887	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,252,843	832,235	3,085,078	0.202895	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	695,671	1,724,356	2,420,027	0.274475	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	82,983	164,038	247,021	0.204914	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,873	53,529	56,402	0.374721	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	692,280	9,582,141	10,274,421	0.131227	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,660,100	3,881,862	6,541,962	0.303998	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,255,051	904,001	3,159,052	0.451410	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,247,069	6,056,776	8,303,845	0.346609	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	224,903	224,903	0.566538	0.000000	90.00
90.01	09001	SENIOR CARE	0	757,714	757,714	0.547678	0.000000	90.01
91.00	09100	EMERGENCY	1,340,623	20,675,307	22,015,930	0.186018	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	16,905	4,066,994	4,083,899	0.347410	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	9,231,301	9,231,301	0.456825	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	182,576	182,576			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	31,061,059	127,220,907	158,281,966			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	31,061,059	127,220,907	158,281,966			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SENIOR CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 5:44 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	7,135,716		7,135,716	0	7,135,716	30.00
31.00	03100	INTENSIVE CARE UNIT	966,844		966,844	0	966,844	31.00
43.00	04300	NURSERY	601,831		601,831	0	601,831	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,091,982		3,091,982	0	3,091,982	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	353,419		353,419	0	353,419	52.00
53.00	05300	ANESTHESIOLOGY	67,489		67,489	0	67,489	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,900,583		3,900,583	0	3,900,583	54.00
60.00	06000	LABORATORY	3,436,799		3,436,799	0	3,436,799	60.00
65.00	06500	RESPIRATORY THERAPY	625,948	0	625,948	0	625,948	65.00
66.00	06600	PHYSICAL THERAPY	664,238	0	664,238	0	664,238	66.00
67.00	06700	OCCUPATIONAL THERAPY	50,618	0	50,618	0	50,618	67.00
68.00	06800	SPEECH PATHOLOGY	21,135	0	21,135	0	21,135	68.00
69.00	06900	ELECTROCARDIOLOGY	1,348,279		1,348,279	0	1,348,279	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,988,742		1,988,742	0	1,988,742	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,426,027		1,426,027	0	1,426,027	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,878,191		2,878,191	0	2,878,191	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	127,416		127,416	0	127,416	90.00
90.01	09001	SENIOR CARE	414,983		414,983	0	414,983	90.01
91.00	09100	EMERGENCY	4,095,351		4,095,351	0	4,095,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,418,789		1,418,789		1,418,789	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,217,093		4,217,093	0	4,217,093	95.00
101.00	10100	HOME HEALTH AGENCY	278,702		278,702		278,702	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	39,110,175	0	39,110,175	0	39,110,175	200.00
201.00		Less Observation Beds	1,418,789		1,418,789		1,418,789	201.00
202.00		Total (see instructions)	37,691,386	0	37,691,386	0	37,691,386	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 5:44 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	6,415,606		6,415,606			30.00
31.00	03100	INTENSIVE CARE UNIT	793,675		793,675			31.00
43.00	04300	NURSERY	1,536,819		1,536,819			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,993,397	8,372,230	11,365,627	0.272047	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	485,715	475,726	961,441	0.367593	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	941,595	1,361,225	2,302,820	0.029307	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,075,210	36,577,219	38,652,429	0.100914	0.000000	54.00
60.00	06000	LABORATORY	3,572,644	22,096,774	25,669,418	0.133887	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,252,843	832,235	3,085,078	0.202895	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	695,671	1,724,356	2,420,027	0.274475	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	82,983	164,038	247,021	0.204914	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,873	53,529	56,402	0.374721	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	692,280	9,582,141	10,274,421	0.131227	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,660,100	3,881,862	6,541,962	0.303998	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,255,051	904,001	3,159,052	0.451410	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,247,069	6,056,776	8,303,845	0.346609	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	224,903	224,903	0.566538	0.000000	90.00
90.01	09001	SENIOR CARE	0	757,714	757,714	0.547678	0.000000	90.01
91.00	09100	EMERGENCY	1,340,623	20,675,307	22,015,930	0.186018	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	16,905	4,066,994	4,083,899	0.347410	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	9,231,301	9,231,301	0.456825	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	182,576	182,576			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	31,061,059	127,220,907	158,281,966			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	31,061,059	127,220,907	158,281,966			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 5:44 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SENIOR CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | Hospital | Cost

		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	487,740	11,365,627	0.042914	744,551	31,952	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,514	961,441	0.004695	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,769	2,302,820	0.000768	135,375	104	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	336,118	38,652,429	0.008696	828,744	7,207	54.00
60.00	06000	LABORATORY	168,544	25,669,418	0.006566	1,362,197	8,944	60.00
65.00	06500	RESPIRATORY THERAPY	33,502	3,085,078	0.010859	796,602	8,650	65.00
66.00	06600	PHYSICAL THERAPY	102,858	2,420,027	0.042503	444,100	18,876	66.00
67.00	06700	OCCUPATIONAL THERAPY	523	247,021	0.002117	46,553	99	67.00
68.00	06800	SPEECH PATHOLOGY	195	56,402	0.003457	1,468	5	68.00
69.00	06900	ELECTROCARDIOLOGY	66,075	10,274,421	0.006431	380,295	2,446	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	130,192	6,541,962	0.019901	1,261,717	25,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,188	3,159,052	0.004175	986,587	4,119	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,772	8,303,845	0.007078	1,008,423	7,138	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	80,566	224,903	0.358226	0	0	90.00
90.01	09001	SENIOR CARE	47,882	757,714	0.063193	0	0	90.01
91.00	09100	EMERGENCY	335,319	22,015,930	0.015231	75,564	1,151	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	163,017	4,083,899	0.039917	93	4	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,030,774	140,121,989		8,072,269	115,804	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | Hospital | Cost

		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	11,365,627	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	961,441	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,302,820	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,652,429	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	25,669,418	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,085,078	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,420,027	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	247,021	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	56,402	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,274,421	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,541,962	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,159,052	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,303,845	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	224,903	0.000000	90.00
90.01	09001	SENIOR CARE	0	0	0	757,714	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	22,015,930	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,083,899	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	140,121,989		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | Hospital | Cost

		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	744,551	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	135,375	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	828,744	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,362,197	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	796,602	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	444,100	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	46,553	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,468	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	380,295	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,261,717	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	986,587	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,008,423	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	75,564	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	93	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		8,072,269	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | 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	0.272047	0	2,228,691	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.367593	0	883	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029307	0	300,600	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100914	0	11,482,315	0	0	54.00
60.00	06000	LABORATORY	0.133887	0	5,850,337	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.202895	0	328,176	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.274475	0	474,617	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.204914	0	39,999	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.374721	0	22,371	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.131227	0	3,758,448	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303998	0	933,571	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.451410	0	174,700	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346609	0	3,166,964	1,471	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.566538	0	92,895	0	0	90.00
90.01	09001	SENIOR CARE	0.547678	0	531,470	0	0	90.01
91.00	09100	EMERGENCY	0.186018	0	5,418,286	1,107	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.347410	0	1,620,721	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.456825		0			95.00
200.00		Subtotal (see instructions)		0	36,425,044	2,578	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	36,425,044	2,578	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | 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	606,309	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	325	0	52.00
53.00	05300	ANESTHESIOLOGY	8,810	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,158,726	0	54.00
60.00	06000	LABORATORY	783,284	0	60.00
65.00	06500	RESPIRATORY THERAPY	66,585	0	65.00
66.00	06600	PHYSICAL THERAPY	130,271	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,196	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,383	0	68.00
69.00	06900	ELECTROCARDIOLOGY	493,210	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	283,804	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	78,861	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,097,698	510	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	52,629	0	90.00
90.01	09001	SENIOR CARE	291,074	0	90.01
91.00	09100	EMERGENCY	1,007,899	206	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	563,055	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	6,639,119	716	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	6,639,119	716	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | Swing Beds - SNF | 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	0.272047	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.367593	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029307	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100914	0	0	0	0	54.00
60.00	06000	LABORATORY	0.133887	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.202895	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.274475	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.204914	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.374721	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.131227	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303998	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.451410	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346609	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.566538	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.547678	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.186018	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.347410	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.456825		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | Swing Beds - SNF | 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	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SENIOR CARE	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 5:44 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	0.272047	0	135,594	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.367593	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029307	0	24,125	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100914	0	435,059	0	0	54.00
60.00	06000	LABORATORY	0.133887	0	322,981	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.202895	0	29,891	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.274475	0	16,467	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.204914	0	635	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.374721	0	8,095	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.131227	0	93,863	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303998	0	111,922	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.451410	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346609	0	49,239	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.566538	0	492	0	0	90.00
90.01	09001	SENIOR CARE	0.547678	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.186018	0	386,270	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.347410	0	116,351	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.456825	0	0			95.00
200.00		Subtotal (see instructions)		0	1,730,984	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	1,730,984	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 5:44 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	36,888	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	707	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,904	0	54.00
60.00	06000	LABORATORY	43,243	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,065	0	65.00
66.00	06600	PHYSICAL THERAPY	4,520	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	130	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,033	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,317	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,024	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,067	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	279	0	90.00
90.01	09001	SENIOR CARE	0	0	90.01
91.00	09100	EMERGENCY	71,853	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	40,422	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	314,452	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	314,452	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | Hospital | Cost

	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)	5,565	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,491	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,388	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	54	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	20	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)	1,972	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)	54	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	158.12	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)	7,135,716	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)	3,162	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)	72,622	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,063,094	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)	7,063,094	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)	1,286.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,536,584	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)	2,536,584	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	966,844	324	2,984.09	158	471,486	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)	2,008,577	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,016,647	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	69,460	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)	69,460	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)	1,103	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,286.30	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,418,789	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | Hospital | Cost

	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	819,885	7,135,716	0.114899	1,418,789	163,017	90.00
91.00	Nursing School cost	0	7,135,716	0.000000	1,418,789	0	91.00
92.00	Allied health cost	0	7,135,716	0.000000	1,418,789	0	92.00
93.00	All other Medical Education	0	7,135,716	0.000000	1,418,789	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 5:44 pm

Title XIX | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,565	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,491	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,388	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	54	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	20	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)	81	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)	859	15.00
16.00	Nursery days (title V or XIX only)	26	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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	158.12	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,135,716	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)	69,491	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,066,225	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)	7,066,225	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)	1,286.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	104,236	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)	104,236	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 5:44 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	601,831	859	700.62	26	18,216	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	966,844	324	2,984.09	11	32,825	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)	134,183	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	289,460	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,103	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,286.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,419,418	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 5:44 pm

Title XIX | Hospital | Cost

	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	819,885	7,135,716	0.114899	1,419,418	163,090	90.00
91.00	Nursing School cost	0	7,135,716	0.000000	1,419,418	0	91.00
92.00	Allied health cost	0	7,135,716	0.000000	1,419,418	0	92.00
93.00	All other Medical Education	0	7,135,716	0.000000	1,419,418	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | 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		2,959,937		30.00
31.00	03100	INTENSIVE CARE UNIT		433,552		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.272047	744,551	202,553	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.367593	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029307	135,375	3,967	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100914	828,744	83,632	54.00
60.00	06000	LABORATORY	0.133887	1,362,197	182,380	60.00
65.00	06500	RESPIRATORY THERAPY	0.202895	796,602	161,627	65.00
66.00	06600	PHYSICAL THERAPY	0.274475	444,100	121,894	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.204914	46,553	9,539	67.00
68.00	06800	SPEECH PATHOLOGY	0.374721	1,468	550	68.00
69.00	06900	ELECTROCARDIOLOGY	0.131227	380,295	49,905	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303998	1,261,717	383,559	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.451410	986,587	445,355	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346609	1,008,423	349,528	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.566538	0	0	90.00
90.01	09001	SENIOR CARE	0.547678	0	0	90.01
91.00	09100	EMERGENCY	0.186018	75,564	14,056	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.347410	93	32	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,072,269	2,008,577	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		8,072,269		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | Swing Beds - SNF | 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.272047	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.367593	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029307	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100914	2,208	223	54.00
60.00	06000	LABORATORY	0.133887	5,070	679	60.00
65.00	06500	RESPIRATORY THERAPY	0.202895	2,272	461	65.00
66.00	06600	PHYSICAL THERAPY	0.274475	41,409	11,366	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.204914	14,662	3,004	67.00
68.00	06800	SPEECH PATHOLOGY	0.374721	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.131227	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303998	3,763	1,144	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.451410	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346609	10,539	3,653	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.566538	0	0	90.00
90.01	09001	SENIOR CARE	0.547678	0	0	90.01
91.00	09100	EMERGENCY	0.186018	823	153	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.347410	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		80,746	20,683	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)		80,746		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 5:44 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		164,193		30.00
31.00	03100	INTENSIVE CARE UNIT		30,184		31.00
43.00	04300	NURSERY		63,117		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.272047	76,481	20,806	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.367593	23,357	8,586	52.00
53.00	05300	ANESTHESIOLOGY	0.029307	27,235	798	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100914	45,660	4,608	54.00
60.00	06000	LABORATORY	0.133887	101,045	13,529	60.00
65.00	06500	RESPIRATORY THERAPY	0.202895	50,646	10,276	65.00
66.00	06600	PHYSICAL THERAPY	0.274475	17,054	4,681	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.204914	3,887	797	67.00
68.00	06800	SPEECH PATHOLOGY	0.374721	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.131227	13,748	1,804	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303998	156,150	47,469	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.451410	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346609	45,462	15,758	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.566538	0	0	90.00
90.01	09001	SENIOR CARE	0.547678	0	0	90.01
91.00	09100	EMERGENCY	0.186018	27,262	5,071	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.347410	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		587,987	134,183	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)		587,987		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 5:44 pm

Title XIX | Swing Beds - SNF | 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
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.272047	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.367593	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029307	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100914	0	0	54.00
60.00	06000	LABORATORY	0.133887	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.202895	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.274475	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.204914	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.374721	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.131227	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303998	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.451410	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346609	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.566538	0	0	90.00
90.01	09001	SENIOR CARE	0.547678	0	0	90.01
91.00	09100	EMERGENCY	0.186018	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.347410	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		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: 15-1331	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/30/2019 5:44 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,639,835	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	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)	6,639,835	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,706,233	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	75,583	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6,125,801	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)	504,849	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)	504,849	30.00
31.00	Primary payer payments	956	31.00
32.00	Subtotal (line 30 minus line 31)	503,893	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)	893,021	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	580,464	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	711,413	36.00
37.00	Subtotal (see instructions)	1,084,357	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,084,357	40.00
40.01	Sequestration adjustment (see instructions)	21,687	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,924,547	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-861,877	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: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | Hospital | Cost

		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		4,222,302		1,924,547	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	08/13/2018	175,400		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)		175,400		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)		4,397,702		1,924,547	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		43,612		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		861,877	6.02
7.00	Total Medicare program liability (see instructions)		4,441,314		1,062,670	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: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | Swing Beds - SNF | Cost

		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		90,917		0	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)		90,917		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		1,693		0	6.02
7.00	Total Medicare program liability (see instructions)		89,224		0	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: 15-1331	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/30/2019 5:44 pm
	Title XVIII	Hospital	Cost

			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 - SWING BEDS

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 5/30/2019 5:44 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	70,155	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	20,890	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	54	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	91,045	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	91,045	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	91,045	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	91,045	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	91,045	0	19.00
19.01	Sequestration adjustment (see instructions)	1,821	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	90,917	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-1,693	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1331 Component CCN: 15-Z331	Period: From 01/01/2018 To 12/31/2018	Worksheet E-2 Date/Time Prepared: 5/30/2019 5:44 pm
	Title XIX	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	0		3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/30/2019 5:44 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,016,647	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	5,016,647	4.00
5.00	Primary payer payments	6,545	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,060,268	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,060,268	19.00
20.00	Deductibles (exclude professional component)	545,299	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,514,969	22.00
23.00	Coinsurance	335	23.00
24.00	Subtotal (line 22 minus line 23)	4,514,634	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	26,644	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	17,319	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	15,723	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,531,953	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	4,531,953	30.00
30.01	Sequestration adjustment (see instructions)	90,639	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	4,397,702	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	43,612	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

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

Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/30/2019 5:44 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,382,969	0	0	0	1.00
2.00	Temporary investments	1,126,303	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	30,903,275	0	0	0	4.00
5.00	Other receivable	610,430	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-22,522,204	0	0	0	6.00
7.00	Inventory	1,264,855	0	0	0	7.00
8.00	Prepaid expenses	629,899	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)	13,395,527	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,001,138	0	0	0	12.00
13.00	Land improvements	3,379,433	0	0	0	13.00
14.00	Accumulated depreciation	-2,382,005	0	0	0	14.00
15.00	Buildings	41,249,261	0	0	0	15.00
16.00	Accumulated depreciation	-22,004,768	0	0	0	16.00
17.00	Leasehold improvements	3,605,135	0	0	0	17.00
18.00	Accumulated depreciation	-2,154,381	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	27,380,236	0	0	0	23.00
24.00	Accumulated depreciation	-23,036,747	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)	29,037,302	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	8,399,147	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	574,365	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,973,512	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	51,406,341	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,054,213	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,421,505	0	0	0	38.00
39.00	Payroll taxes payable	39,664	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	427,441	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,942,823	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,983,182	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,983,182	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,926,005	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	34,480,336				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)	34,480,336	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	51,406,341	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/30/2019 5:44 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		38,081,643		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,601,307				2.00
3.00	Total (sum of line 1 and line 2)		34,480,336		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)		34,480,336		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		34,480,336		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2019 5:44 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	14,286,528		14,286,528	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	14,286,528		14,286,528	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,070,469		1,070,469	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)	1,070,469		1,070,469	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15,356,997		15,356,997	17.00
18.00	Ancillary services	19,453,311	94,692,939	114,146,250	18.00
19.00	Outpatient services	382,487	20,534,359	20,916,846	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		182,576	182,576	22.00
23.00	AMBULANCE SERVICES	0	9,231,301	9,231,301	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER	1,599,737	17,204,370	18,804,107	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	36,792,532	141,845,545	178,638,077	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		58,853,884		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)		58,853,884		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/30/2019 5:44 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	178,638,077	1.00
2.00	Less contractual allowances and discounts on patients' accounts	126,127,793	2.00
3.00	Net patient revenues (line 1 minus line 2)	52,510,284	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	58,853,884	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,343,600	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-60,665	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	1,355	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	134,956	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	25,286	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	1,076,301	22.00
23.00	Governmental appropriations	1,202,683	23.00
24.00	IDENTIFIED ON TRIAL BALANCE	362,377	24.00
25.00	Total other income (sum of lines 6-24)	2,742,293	25.00
26.00	Total (line 5 plus line 25)	-3,601,307	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,601,307	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H | Date/Time Prepared: 5/30/2019 5:44 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	28,776	23,448	4,074	0	43,158	99,456	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	42,378	0	0	0	0	42,378	6.00
7.00	Physical Therapy	51,783	0	0	0	0	51,783	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	21,447	0	0	0	0	21,447	11.00
12.00	Supplies (see instructions)	0	0	0	0	7,510	7,510	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	144,384	23,448	4,074	0	50,668	222,574	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	1,163	100,619	-23,448	77,171			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	-595	41,783	0	41,783			6.00
7.00	Physical Therapy	-790	50,993	0	50,993			7.00
8.00	Occupational Therapy	295	295	0	295			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	-73	21,374	0	21,374			11.00
12.00	Supplies (see instructions)	0	7,510	0	7,510			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	222,574	-23,448	199,126			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-1 Part I | Date/Time Prepared: 5/30/2019 5:44 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	77,171	0	0	0	0	77,171	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	41,783	0	0	0	0	41,783	6.00
7.00	Physical Therapy	50,993	0	0	0	0	50,993	7.00
8.00	Occupational Therapy	295	0	0	0	0	295	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	21,374	0	0	0	0	21,374	11.00
12.00	Supplies (see instructions)	7,510	0	0	0	0	7,510	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	199,126	0	0	0	0	199,126	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	77,171		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	26,440	68,223	6.00
7.00	Physical Therapy	32,267	83,260	7.00
8.00	Occupational Therapy	187	482	8.00
9.00	Speech Pathology	0	0	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	13,525	34,899	11.00
12.00	Supplies (see instructions)	4,752	12,262	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		199,126	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1331 HHA CCN: 15-7242 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-1 Part II Date/Time Prepared: 5/30/2019 5:44 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-77,171	121,955	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	41,783	6.00
7.00	Physical Therapy	0	0	0	0	0	50,993	7.00
8.00	Occupational Therapy	0	0	0	0	0	295	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	21,374	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	7,510	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-77,171	121,955	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		77,171	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.632783	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-2 Part I | Date/Time Prepared: 5/30/2019 5:44 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	MOB	AMB DEPR	MVBLE EQUIP	AMB EQUIP	
		0	1.00	1.01	1.02	2.00	2.01	
1.00	Administrative and General	0	0	9,311	0	0	0	1.00
2.00	Skilled Nursing Care	68,223	0	0	0	0	0	2.00
3.00	Physical Therapy	83,260	0	0	0	0	0	3.00
4.00	Occupational Therapy	482	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	34,899	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	12,262	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	199,126	0	9,311	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OPERATION OF PLANT	
		4.00	4A	5.01	5.02	5.03	7.00	
1.00	Administrative and General	8,256	17,567	1,894	847	1,550	0	1.00
2.00	Skilled Nursing Care	11,521	79,744	8,599	0	0	0	2.00
3.00	Physical Therapy	14,061	97,321	10,494	0	0	0	3.00
4.00	Occupational Therapy	81	563	61	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	5,894	40,793	4,399	0	0	0	7.00
8.00	Supplies (see instructions)	0	12,262	1,322	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	39,813	248,250	26,769	847	1,550	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-2 Part I | Date/Time Prepared: 5/30/2019 5:44 pm

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	Cost Center Description	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.01	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	17.00	24.00	25.00	
1.00	Administrative and General	0	0	1,286	0	23,144	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	88,343	0	2.00
3.00	Physical Therapy	0	0	0	0	107,815	0	3.00
4.00	Occupational Therapy	0	0	0	0	624	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	45,192	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	13,584	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	1,286	0	278,702	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1331
HHA CCN: 15-7242

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

Worksheet H-2 Part I
Date/Time Prepared: 5/30/2019 5:44 pm

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	Cost Center Description	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		26.00	27.00	28.00			
1.00	Administrative and General	23,144					1.00
2.00	Skilled Nursing Care	88,343	8,001	96,344			2.00
3.00	Physical Therapy	107,815	9,763	117,578			3.00
4.00	Occupational Therapy	624	57	681			4.00
5.00	Speech Pathology	0	0	0			5.00
6.00	Medical Social Services	0	0	0			6.00
7.00	Home Health Aide	45,192	4,093	49,285			7.00
8.00	Supplies (see instructions)	13,584	1,230	14,814			8.00
9.00	Drugs	0	0	0			9.00
10.00	DME	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0			13.00
14.00	Clinic	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0			15.00
16.00	Day Care Program	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0			17.00
18.00	Homemaker Service	0	0	0			18.00
19.00	All Others (specify)	0	0	0			19.00
19.50	Telemedicine	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	278,702	23,144	278,702			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.090563				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-2 Part II | Date/Time Prepared: 5/30/2019 5:44 pm

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	Cost Center Description	CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQ UARE FEET)	MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQ UARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		1.00	1.01	1.02	2.00	2.01	4.00	
1.00	Administrative and General	0	476	0	0	0	29,940	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	41,782	2.00
3.00	Physical Therapy	0	0	0	0	0	50,993	3.00
4.00	Occupational Therapy	0	0	0	0	0	295	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	21,374	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	476	0	0	0	144,384	20.00
21.00	Total cost to be allocated	0	9,311	0	0	0	39,813	21.00
22.00	Unit cost multiplier	0.000000	19.560924	0.000000	0.000000	0.000000	0.275744	22.00

	Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	OPERATION OF PLANT (SQUARE FEET)	AMB PLANT OPS (SQUARE FEET)	
		5A.01	5.01	5.02	5.03	7.00	7.01	
1.00	Administrative and General	0	17,567	182,576	182,576	0	0	1.00
2.00	Skilled Nursing Care	0	79,744	0	0	0	0	2.00
3.00	Physical Therapy	0	97,321	0	0	0	0	3.00
4.00	Occupational Therapy	0	563	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	40,793	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	12,262	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)		248,250	182,576	182,576	0	0	20.00
21.00	Total cost to be allocated		26,769	847	1,550	0	0	21.00
22.00	Unit cost multiplier		0.107831	0.004639	0.008490	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1331 HHA CCN: 15-7242

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

Worksheet H-2 Part II Date/Time Prepared: 5/30/2019 5:44 pm

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	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATI ENT DAYS)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	0	20.00
21.00	Total cost to be allocated	0	0	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

	Cost Center Description	PHARMACY (TIME SPENT)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)				
		15.00	16.00	17.00				
1.00	Administrative and General	0	182,576	0				1.00
2.00	Skilled Nursing Care	0	0	0				2.00
3.00	Physical Therapy	0	0	0				3.00
4.00	Occupational Therapy	0	0	0				4.00
5.00	Speech Pathology	0	0	0				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	0	0	0				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19)	0	182,576	0				20.00
21.00	Total cost to be allocated	0	1,286	0				21.00
22.00	Unit cost multiplier	0.000000	0.007044	0.000000				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part I | Date/Time Prepared: 5/30/2019 5:44 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	96,344		96,344	462	208.54	1.00
2.00	Physical Therapy	3.00	117,578	0	117,578	232	506.80	2.00
3.00	Occupational Therapy	4.00	681	0	681	2	340.50	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	49,285		49,285	280	176.02	6.00
7.00	Total (sum of lines 1-6)		263,888	0	263,888	976		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		31140	0	324			8.00
8.01	Skilled Nursing Care		99915	0	102			8.01
9.00	Physical Therapy		31140	0	186			9.00
9.01	Physical Therapy		99915	0	31			9.01
10.00	Occupational Therapy		31140	0	2			10.00
10.01	Occupational Therapy		99915	0	0			10.01
11.00	Speech Pathology		31140	0	0			11.00
11.01	Speech Pathology		99915	0	0			11.01
12.00	Medical Social Services		31140	0	0			12.00
12.01	Medical Social Services		99915	0	0			12.01
13.00	Home Health Aide		31140	0	229			13.00
13.01	Home Health Aide		99915	0	48			13.01
14.00	Total (sum of lines 8-13)			0	922			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	14,814	0	14,814	7,510	1.972570	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	426		0	88,838		1.00
2.00	Physical Therapy	0	217		0	109,976		2.00
3.00	Occupational Therapy	0	2		0	681		3.00
4.00	Speech Pathology	0	0		0	0		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	277		0	48,758		6.00
7.00	Total (sum of lines 1-6)	0	922		0	248,253		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-1331 HHA CCN: 15-7242 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part I Date/Time Prepared: 5/30/2019 5:44 pm

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	3,701	0	0	7,300	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	88,838						1.00
2.00	Physical Therapy	109,976						2.00
3.00	Occupational Therapy	681						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	48,758						6.00
7.00	Total (sum of lines 1-6)	248,253						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1331
HHA CCN: 15-7242

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

Worksheet H-3
Part II
Date/Time Prepared:
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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.274475	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.204914	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.374721	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.303998	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.346609	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331 HHA CCN: 15-7242	Period: From 01/01/2018 To 12/31/2018	Worksheet H-4 Part I-II Date/Time Prepared: 5/30/2019 5:44 pm
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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	105,790	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	9,226	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	2,969	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	9,716	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	4,081	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	131,782	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	131,782	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	131,782	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	131,782	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	131,782	31.00
31.01	Sequestration adjustment (see instructions)	0	2,636	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	129,146	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-5 | Date/Time Prepared: 5/30/2019 5:44 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		129,146	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		129,146	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		129,146	7.00

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