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: 15-0072	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 4/1/2019 4:24 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 4/1/2019 Time: 4:24 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 MEMORIAL HOSPITAL LOGANSPORT (15-0072) 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	15,771	60,802	0	-89,735	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	15,771	60,802	0	-89,735	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: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 4/1/2019 4:24 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1101 MICHIGAN AVENUE	PO Box:			1.00
2.00	City: LOGANSPORT	State: IN	Zip Code: 46947-	County: CASS	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	MEMORIAL HOSPITAL LOGANSPORT	150072	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SWING BED - SNF	15U072	99915		05/14/2008	N	P	P	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	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.	Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	182	0	0	0	1,333	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 4/1/2019 4:24 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.	1		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	01/01/2018	12/31/2018	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

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

		V	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: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 4/1/2019 4:24 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: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 4/1/2019 4:24 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0072	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 4/1/2019 4:24 pm

		1.00	2.00	3.00	
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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	633,275	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0072	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 4/1/2019 4:24 pm

		1.00	2.00	
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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0072	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 4/1/2019 4:24 pm

		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: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 4/1/2019 4:24 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			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)	Y	03/04/2019	Y	03/04/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 4/1/2019 4:24 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N	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.	MICHAEL	ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959	MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0072	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 4/1/2019 4:24 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.	DIRECTOR		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: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 4/1/2019 4:24 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	39	12,959	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		39	12,959	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		44	14,784	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		44				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)		5	1,825			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: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 4/1/2019 4:24 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)	1,668	182	3,777			1.00
2.00	HMO and other (see instructions)	16	1,333				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,668	182	3,777			7.00
8.00	INTENSIVE CARE UNIT	220	0	435			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		0	1,044			13.00
14.00	Total (see instructions)	1,888	182	5,256	0.00	496.31	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	496.31	27.00
28.00	Observation Bed Days		14	1,059			28.00
29.00	Ambulance Trips	1					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	262			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 4/1/2019 4:24 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	664	79	1,659	1.00
2.00	HMO and other (see instructions)			5	574		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	664	79	1,659	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 4/1/2019 4:24 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	32,606,351	0	32,606,351	1,024,316.00	31.83	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		3,883,917	0	3,883,917	44,030.00	88.21	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		4,679,287	2,537,099	7,216,386	155,474.00	46.42	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		314,684	0	314,684	3,216.00	97.85	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,210,495	0	8,210,495			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,823,769	0	1,823,769			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		598,407	0	598,407			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II | Date/Time Prepared: 4/1/2019 4:24 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	309,030	0	309,030	10,365.00	29.81	26.00
27.00	Administrative & General	5.00	3,573,780	0	3,573,780	149,811.00	23.86	27.00
28.00	Administrative & General under contract (see inst.)		319,644	0	319,644	1,567.00	203.98	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	639,692	0	639,692	21,856.00	29.27	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	528,712	0	528,712	40,383.00	13.09	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	453,299	-340,560	112,739	8,401.00	13.42	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	340,560	340,560	26,246.00	12.98	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	609,609	0	609,609	15,035.00	40.55	38.00
39.00	Central Services and Supply	14.00	230,992	0	230,992	14,632.00	15.79	39.00
40.00	Pharmacy	15.00	509,667	0	509,667	14,893.00	34.22	40.00
41.00	Medical Records & Medical Records Library	16.00	696,528	0	696,528	32,777.00	21.25	41.00
42.00	Social Service	17.00	315,832	0	315,832	11,472.00	27.53	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 4/1/2019 4:24 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		29,042,078	0	29,042,078	981,853.00	29.58	1.00
2.00	Excluded area salaries (see instructions)		4,679,287	2,537,099	7,216,386	155,474.00	46.42	2.00
3.00	Subtotal salaries (line 1 minus line 2)		24,362,791	-2,537,099	21,825,692	826,379.00	26.41	3.00
4.00	Subtotal other wages & related costs (see inst.)		314,684	0	314,684	3,216.00	97.85	4.00
5.00	Subtotal wage-related costs (see inst.)		8,210,495	0	8,210,495	0.00	37.62	5.00
6.00	Total (sum of lines 3 thru 5)		32,887,970	-2,537,099	30,350,871	829,595.00	36.59	6.00
7.00	Total overhead cost (see instructions)		8,186,785	0	8,186,785	347,438.00	23.56	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 4/1/2019 4:24 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	267,427	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	7,313,594	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	159,797	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	47,867	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	317,165	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	340,189	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,135,661	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	12,089	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	38,881	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,632,670	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 4/1/2019 4:24 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	10,632,670	1.00
2.00	Hospital	0	10,632,670	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 4/1/2019 4:24 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)	0.291857	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,501,881	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	25,543,150	6.00
7.00	Medicaid cost (line 1 times line 6)	7,454,947	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)	0	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)	0	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)	808,964	675,412	1,484,376	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	236,102	675,412	911,514	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)	236,102	675,412	911,514	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)	10,015,631	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	92,503	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	142,311	27.01
28.00	Non-Medicare bad debt expense (see instructions)	9,873,320	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,931,406	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,842,920	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,842,920	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 4/1/2019 4:24 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	NEW CAP REL COSTS-BLDG & FIXT		5,148,268	5,148,268	-309,575	4,838,693	1.00
1.01	00101	MOB		225,503	225,503	0	225,503	1.01
1.02	00102	OPS		147,326	147,326	0	147,326	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	309,030	11,358,191	11,667,221	0	11,667,221	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,573,780	6,238,298	9,812,078	458,437	10,270,515	5.00
7.00	00700	OPERATION OF PLANT	639,692	2,150,641	2,790,333	19,876	2,810,209	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	169,210	169,210	0	169,210	8.00
9.00	00900	HOUSEKEEPING	528,712	216,533	745,245	0	745,245	9.00
10.00	01000	DIETARY	453,299	726,875	1,180,174	-886,656	293,518	10.00
11.00	01100	CAFETERIA	0	0	0	886,656	886,656	11.00
13.00	01300	NURSING ADMINISTRATION	609,609	10,740	620,349	0	620,349	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	230,992	246,103	477,095	0	477,095	14.00
15.00	01500	PHARMACY	509,667	411,976	921,643	0	921,643	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	696,528	530,036	1,226,564	0	1,226,564	16.00
17.00	01700	SOCIAL SERVICE	315,832	19,573	335,405	0	335,405	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,559,450	544,857	4,104,307	-1,090,165	3,014,142	30.00
31.00	03100	INTENSIVE CARE UNIT	572,004	40,011	612,015	0	612,015	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	266	266	326,953	327,219	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,278,720	1,033,745	5,312,465	-2,971,011	2,341,454	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	877	877	763,212	764,089	52.00
53.00	05300	ANESTHESIOLOGY	0	964,761	964,761	0	964,761	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,053,869	857,015	1,910,884	0	1,910,884	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,760,076	2,760,076	0	2,760,076	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	124,887	124,887	0	124,887	63.00
65.00	06500	RESPIRATORY THERAPY	588,114	165,256	753,370	0	753,370	65.00
66.00	06600	PHYSICAL THERAPY	171,607	753,951	925,558	0	925,558	66.00
69.00	06900	ELECTROCARDIOLOGY	354,637	117,223	471,860	0	471,860	69.00
69.01	06901	CARDIAC REHAB	325,326	21,339	346,665	0	346,665	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,692,523	2,692,523	-1,489,183	1,203,340	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,489,183	1,489,183	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,014,435	7,014,435	0	7,014,435	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	213,927	196,456	410,383	0	410,383	76.00
76.01	03040	RADIATION ONCOLOGY	586,117	1,571,061	2,157,178	-19,876	2,137,302	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,749,202	1,051,245	7,800,447	0	7,800,447	90.00
90.01	09001	WOUND CARE	122,795	571,993	694,788	0	694,788	90.01
91.00	09100	EMERGENCY	1,484,155	945,552	2,429,707	0	2,429,707	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,927,064	49,026,802	76,953,866	-2,822,149	74,131,717	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	2,276	2,276	0	2,276	194.00
194.01	07951	MOB	0	721	721	0	721	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	526,202	184,990	711,192	-60	711,132	194.04
194.05	07955	PHYSICIANS OFFICE	3,884,860	546,838	4,431,698	2,826,885	7,258,583	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	1,306	237,028	238,334	-3,318	235,016	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	48,522	64,504	113,026	0	113,026	194.09
194.10	07961	RHEUMATOLOGY	135,206	4,296	139,502	-1,358	138,144	194.10
194.11	07960	SPORTS HEALTH	83,191	47,435	130,626	0	130,626	194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	32,606,351	50,114,890	82,721,241	0	82,721,241	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 4/1/2019 4:24 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-19,677	4,819,016		1.00
1.01	00101	MOB	0	225,503		1.01
1.02	00102	OPS	0	147,326		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,838	11,664,383		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,375,853	6,894,662		5.00
7.00	00700	OPERATION OF PLANT	-11,994	2,798,215		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	169,210		8.00
9.00	00900	HOUSEKEEPING	0	745,245		9.00
10.00	01000	DIETARY	-41,654	251,864		10.00
11.00	01100	CAFETERIA	-315,471	571,185		11.00
13.00	01300	NURSING ADMINISTRATION	-2,333	618,016		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-73,748	403,347		14.00
15.00	01500	PHARMACY	0	921,643		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-29,424	1,197,140		16.00
17.00	01700	SOCIAL SERVICE	0	335,405		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,105,285	1,908,857		30.00
31.00	03100	INTENSIVE CARE UNIT	0	612,015		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	327,219		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,341,454		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	764,089		52.00
53.00	05300	ANESTHESIOLOGY	-878,972	85,789		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,910,884		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	2,760,076		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	124,887		63.00
65.00	06500	RESPIRATORY THERAPY	0	753,370		65.00
66.00	06600	PHYSICAL THERAPY	0	925,558		66.00
69.00	06900	ELECTROCARDIOLOGY	0	471,860		69.00
69.01	06901	CARDIAC REHAB	-1,500	345,165		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,203,340		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,489,183		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,014,435		73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	410,383		76.00
76.01	03040	RADIATION ONCOLOGY	-1,382,740	754,562		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-4,626,794	3,173,653		90.00
90.01	09001	WOUND CARE	-497,213	197,575		90.01
91.00	09100	EMERGENCY	-762,639	1,667,068		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,128,135	61,003,582		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	FOUNDATION	0	2,276		194.00
194.01	07951	MOB	0	721		194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0		194.02
194.03	07953	PIH	0	0		194.03
194.04	07954	HEALTH COMPANIES	0	711,132		194.04
194.05	07955	PHYSICIANS OFFICE	0	7,258,583		194.05
194.06	07956	THE ARBORS	0	0		194.06
194.07	07957	PAIN MANAGEMENT	0	235,016		194.07
194.08	07958	OPS	0	0		194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	113,026		194.09
194.10	07961	RHEUMATOLOGY	0	138,144		194.10
194.11	07960	SPORTS HEALTH	0	130,626		194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,128,135	69,593,106		200.00

RECLASSIFICATIONS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 4/1/2019 4:24 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	340,560	546,096		1.00
	0		340,560	546,096		
	B - OB RECLASS					
1.00	NURSERY	43.00	282,271	44,682		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	659,131	104,081		2.00
	0		941,402	148,763		
	C - MALPRACTICE INS. RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	458,437		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		0	458,437		
	D - IMPLANT EXPENSE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,489,183		1.00
	0		0	1,489,183		
	E - SURGICAL SERVICES RECLASS					
1.00	PHYSICIANS OFFICE	194.05	2,537,099	433,912		1.00
	TOTALS		2,537,099	433,912		
	F - UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7.00	0	19,876		1.00
	TOTALS		0	19,876		
500.00	Grand Total: Increases		3,819,061	3,096,267		500.00

RECLASSIFICATIONS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 4/1/2019 4:24 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	340,560	546,096	0		1.00
	0		340,560	546,096			
	B - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	941,402	148,763	0		1.00
2.00		0.00	0	0	0		2.00
	0		941,402	148,763			
	C - MALPRACTICE INS. RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	309,575	12		1.00
2.00	HEALTH COMPANIES	194.04	0	60	0		2.00
3.00	PHYSICIANS OFFICE	194.05	0	144,126	0		3.00
4.00	PAIN MANAGEMENT	194.07	0	3,318	0		4.00
5.00	RHEUMATOLOGY	194.10	0	1,358	0		5.00
	0		0	458,437			
	D - IMPLANT EXPENSE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,489,183	0		1.00
	0		0	1,489,183			
	E - SURGICAL SERVICES RECLASS						
1.00	OPERATING ROOM	50.00	2,537,099	433,912	0		1.00
	TOTALS		2,537,099	433,912			
	F - UTILITIES RECLASS						
1.00	RADIATION ONCOLOGY	76.01	0	19,876	0		1.00
	TOTALS		0	19,876			
500.00	Grand Total: Decreases		3,819,061	3,096,267			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 4/1/2019 4:24 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	205,783	0	0	0	0	1.00
2.00	Land Improvements	692,370	177,329	0	177,329	0	2.00
3.00	Buildings and Fixtures	60,823,505	5,871,694	0	5,871,694	0	3.00
4.00	Building Improvements	6,044,627	4,629,549	0	4,629,549	9,030,066	4.00
5.00	Fixed Equipment	42,498,651	3,972,180	0	3,972,180	4,400	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	110,264,936	14,650,752	0	14,650,752	9,034,466	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	110,264,936	14,650,752	0	14,650,752	9,034,466	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	205,783	0	1.00
2.00	Land Improvements	869,699	0	2.00
3.00	Buildings and Fixtures	66,695,199	0	3.00
4.00	Building Improvements	1,644,110	0	4.00
5.00	Fixed Equipment	46,466,431	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	115,881,222	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	115,881,222	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 4/1/2019 4:24 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,293,287	0	463,455	391,526	0	1.00
1.01	MOB	225,503	0	0	0	0	1.01
1.02	OPS	147,326	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	4,666,116	0	463,455	391,526	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	NEW CAP REL COSTS-BLDG & FIXT	0	5,148,268		1.00
1.01	MOB	0	225,503		1.01
1.02	OPS	0	147,326		1.02
3.00	Total (sum of lines 1-2)	0	5,521,097		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III | Date/Time Prepared: 4/1/2019 4:24 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	108,055,987	0	108,055,987	0.932472	0	1.00
1.01	MOB	4,733,038	0	4,733,038	0.040844	0	1.01
1.02	OPS	3,092,197	0	3,092,197	0.026684	0	1.02
3.00	Total (sum of lines 1-2)	115,881,222	0	115,881,222	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	4,273,628	0	1.00
1.01	MOB	0	0	0	225,503	0	1.01
1.02	OPS	0	0	0	147,326	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	4,646,457	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	463,455	81,933	0	0	4,819,016	1.00
1.01	MOB	0	0	0	0	225,503	1.01
1.02	OPS	0	0	0	0	147,326	1.02
3.00	Total (sum of lines 1-2)	463,455	81,933	0	0	5,191,845	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 4/1/2019 4:24 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - MOB (chapter 2)		0	MOB	1.01	0	1.01
1.02	Investment income - OPS (chapter 2)		0	OPS	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-8,842,665			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	A	-315,471	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - MOB		0	MOB	1.01	0	26.01
26.02	Depreciation - OPS		0	OPS	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 4/1/2019 4:24 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	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER REVENUE - MISCELLANEOUS	B	-4,029	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHER REVENUE - BAD DEBT	B	-483	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	OTHER REVENUE - MEDICARE	B	-28	ADMINISTRATIVE & GENERAL	5.00	0	35.00
37.00	OTHER REVENUE - BLUE CROSS	B	-782	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	OTHER REVENUE - MEDICAID	B	-1,965	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	OTHER REVENUE - SCRAP SAL	B	-11,695	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	OTHER REVENUE - CASH OVER	B	-233	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	MHL A/P DISCOUNTS	B	-358	ADMINISTRATIVE & GENERAL	5.00	0	41.00
44.00	MHL TELEPHONE SERVICE	B	-2,082	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	OTHER REVENUE - VENDING COMMISSION	B	-7,782	DIETARY	10.00	0	45.00
45.01	OTHER REVENUE - CASH OVER/SHORT	B	76	DIETARY	10.00	0	45.01
45.02	MEALS ON WHEELS	B	-20,422	DIETARY	10.00	0	45.02
45.03	DIETARY REVENUE	B	-13,526	DIETARY	10.00	0	45.03
45.05	OTHER REVENUE - ACLS REVENUE	B	-140	NURSING ADMINISTRATION	13.00	0	45.05
45.06	OTHER REVENUE - CPR TRAINING	B	-2,193	NURSING ADMINISTRATION	13.00	0	45.06
45.07	OTHER REVENUE - REBATES MMT	B	-73,748	CENTRAL SERVICES & SUPPLY	14.00	0	45.07
45.08	HIM MEDICAL RECORDS FEES	B	-29,424	MEDICAL RECORDS & LIBRARY	16.00	0	45.08
45.09	INTEREST INCOME	B	-18	NEW CAP REL COSTS-BLDG & FIXT	1.00	12	45.09
45.10	PATIENT TELEVISIONS	A	-543	OPERATION OF PLANT	7.00	0	45.10
45.12	PATIENT TELEPHONES	A	-2,838	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.12
45.13	PATIENT TELEPHONES	A	-2,438	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.13
45.14	PATIENT TELEPHONES	A	-1,904	ADMINISTRATIVE & GENERAL	5.00	0	45.14
45.15	IHA & AHA LOBBYING FEES	A	-1,666	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	GIFT SHOP	A	-14,288	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.16
45.17	GIFT SHOP	A	-9,501	OPERATION OF PLANT	7.00	0	45.17
45.18	ADVERTISING	A	-863,180	ADMINISTRATIVE & GENERAL	5.00	0	45.18
45.19	TAXES	A	-27,992	ADMINISTRATIVE & GENERAL	5.00	0	45.19
45.20	DONATION EXPENSE	A	-32,584	ADMINISTRATIVE & GENERAL	5.00	0	45.20
45.21	PHYSICIAN RECRUITMENT	A	-216,830	ADMINISTRATIVE & GENERAL	5.00	0	45.21
45.23	VENDING	A	-2,933	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.23
45.24	VENDING	A	-1,950	OPERATION OF PLANT	7.00	0	45.24
45.25	HOSPITAL ASSESSMENT FEE OFFSET	A	-2,210,042	ADMINISTRATIVE & GENERAL	5.00	0	45.25
45.26	HOSPITALIST OFFSET	A	-412,478	ADULTS & PEDIATRICS	30.00	0	45.26
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,128,135				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: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 4/1/2019 4:24 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	30.00	ADULTS & PEDIATRICS	692,807	692,807	0	237,100	0	1.00
2.00	53.00	ANESTHESIOLOGY	878,972	878,972	0	239,400	0	2.00
3.00	69.01	CARDIAC REHAB	1,500	1,500	0	179,000	0	3.00
4.00	90.00	CLINIC	4,708,020	4,602,075	105,945	179,000	884	4.00
5.00	90.01	WOUND CARE	497,213	497,213	0	179,000	0	5.00
6.00	91.00	EMERGENCY	762,639	762,639	0	246,400	0	6.00
7.00	76.01	RADIATION ONCOLOGY	1,382,740	1,382,740	0	179,000	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			8,923,891	8,817,946	105,945		884	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	30.00	ADULTS & PEDIATRICS	0	0	3,128	0	7,654	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	69.01	CARDIAC REHAB	0	0	0	0	0	3.00
4.00	90.00	CLINIC	76,075	3,804	52,707	1,186	176,196	4.00
5.00	90.01	WOUND CARE	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	76.01	RADIATION ONCOLOGY	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			76,075	3,804	55,835	1,186	183,850	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	30.00	ADULTS & PEDIATRICS	0	0	0	692,807		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	878,972		2.00
3.00	69.01	CARDIAC REHAB	0	0	0	1,500		3.00
4.00	90.00	CLINIC	3,965	81,226	24,719	4,626,794		4.00
5.00	90.01	WOUND CARE	0	0	0	497,213		5.00
6.00	91.00	EMERGENCY	0	0	0	762,639		6.00
7.00	76.01	RADIATION ONCOLOGY	0	0	0	1,382,740		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			3,965	81,226	24,719	8,842,665		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 4/1/2019 4:24 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				NEW BLDG & FIXT	MOB	OPS		
			0	1.00	1.01	1.02	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	4,819,016	4,819,016				1.00
1.01	00101	MOB	225,503	0	225,503			1.01
1.02	00102	OPS	147,326	0	0	147,326		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,664,383	42,664	0	0	11,707,047	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,894,662	367,004	21,160	0	1,295,413	5.00
7.00	00700	OPERATION OF PLANT	2,798,215	903,715	1,370	11,704	231,874	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	169,210	15,970	0	0	0	8.00
9.00	00900	HOUSEKEEPING	745,245	35,753	732	432	191,646	9.00
10.00	01000	DIETARY	251,864	146,674	0	0	40,865	10.00
11.00	01100	CAFETERIA	571,185	73,145	0	0	123,445	11.00
13.00	01300	NURSING ADMINISTRATION	618,016	56,740	0	0	220,969	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	403,347	105,622	0	0	83,729	14.00
15.00	01500	PHARMACY	921,643	53,822	0	0	184,743	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,197,140	190,540	0	0	252,475	16.00
17.00	01700	SOCIAL SERVICE	335,405	36,444	0	0	114,482	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,908,857	756,070	0	0	948,982	30.00
31.00	03100	INTENSIVE CARE UNIT	612,015	135,208	0	0	207,338	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	327,219	23,085	0	0	102,317	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,341,454	498,732	0	2,798	631,298	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	764,089	126,660	0	0	238,920	52.00
53.00	05300	ANESTHESIOLOGY	85,789	45,121	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,910,884	231,054	0	8,309	382,003	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,760,076	123,794	6,930	3,875	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	124,887	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	753,370	8,804	0	0	213,178	65.00
66.00	06600	PHYSICAL THERAPY	925,558	97,765	0	0	62,204	66.00
69.00	06900	ELECTROCARDIOLOGY	471,860	12,259	14,580	0	128,548	69.00
69.01	06901	CARDIAC REHAB	345,165	142,374	0	0	117,923	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,203,340	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,489,183	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,014,435	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	410,383	18,760	0	0	77,544	76.00
76.01	03040	RADIATION ONCOLOGY	754,562	0	0	48,216	212,454	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,173,653	5,375	87,349	0	2,446,442	90.00
90.01	09001	WOUND CARE	197,575	0	14,106	0	44,510	90.01
91.00	09100	EMERGENCY	1,667,068	392,111	0	0	537,972	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,003,582	4,645,265	146,227	75,334	9,091,274	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	2,276	0	0	0	0	194.00
194.01	07951	MOB	721	0	38,285	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	711,132	58,480	0	0	190,736	194.04
194.05	07955	PHYSICIANS OFFICE	7,258,583	115,271	18,414	30,762	2,327,812	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	235,016	0	0	0	473	194.07
194.08	07958	OPS	0	0	0	41,230	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	113,026	0	0	0	17,588	194.09
194.10	07961	RHEUMATOLOGY	138,144	0	22,577	0	49,009	194.10
194.11	07960	SPORTS HEALTH	130,626	0	0	0	30,155	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	69,593,106	4,819,016	225,503	147,326	11,707,047	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 4/1/2019 4:24 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,578,239	8,578,239				5.00
7.00	00700	OPERATION OF PLANT	3,946,878	554,903	4,501,781			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	185,180	26,035	13,919	225,134		8.00
9.00	00900	HOUSEKEEPING	973,808	136,911	36,136	0	1,146,855	9.00
10.00	01000	DIETARY	439,403	61,777	127,836	0	0	10.00
11.00	01100	CAFETERIA	767,775	107,944	63,751	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	895,725	125,933	49,452	0	3,046	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	592,698	83,329	92,057	0	56,041	14.00
15.00	01500	PHARMACY	1,160,208	163,117	46,910	0	6,091	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,640,155	230,594	166,068	0	9,137	16.00
17.00	01700	SOCIAL SERVICE	486,331	68,375	31,764	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,613,909	508,090	658,964	56,172	396,092	30.00
31.00	03100	INTENSIVE CARE UNIT	954,561	134,205	117,843	6,501	60,914	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	452,621	63,635	20,120	15,526	3,655	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,474,282	488,460	446,388	74,232	137,056	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,129,669	158,824	110,393	0	20,406	52.00
53.00	05300	ANESTHESIOLOGY	130,910	18,405	39,326	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,532,250	356,017	236,154	15,584	48,731	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,894,675	406,971	154,112	0	21,320	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	124,887	17,558	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	975,352	137,128	7,673	0	27,411	65.00
66.00	06600	PHYSICAL THERAPY	1,085,527	152,617	85,209	1,264	12,183	66.00
69.00	06900	ELECTROCARDIOLOGY	627,247	88,187	73,811	0	27,411	69.00
69.01	06901	CARDIAC REHAB	605,462	85,124	124,088	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,203,340	169,181	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,489,183	209,369	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,014,435	986,180	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	506,687	71,237	16,350	0	0	76.00
76.01	03040	RADIATION ONCOLOGY	1,015,232	142,735	201,803	0	48,731	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,712,819	803,182	382,861	0	36,548	90.00
90.01	09001	WOUND CARE	256,191	36,019	61,074	0	15,228	90.01
91.00	09100	EMERGENCY	2,597,151	365,141	341,751	55,855	97,462	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,062,790	6,957,183	3,705,813	225,134	1,027,463	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	2,276	320	0	0	9,746	194.00
194.01	07951	MOB	39,006	5,484	165,756	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	960,348	135,018	50,969	0	12,183	194.04
194.05	07955	PHYSICIANS OFFICE	9,750,842	1,370,874	308,939	0	73,097	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	235,489	33,108	0	0	0	194.07
194.08	07958	OPS	41,230	5,797	172,559	0	24,366	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	130,614	18,363	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	209,730	29,487	97,745	0	0	194.10
194.11	07960	SPORTS HEALTH	160,781	22,605	0	0	0	194.11
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)	69,593,106	8,578,239	4,501,781	225,134	1,146,855	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 4/1/2019 4:24 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	629,016					10.00
11.00	01100	CAFETERIA	0	939,470				11.00
13.00	01300	NURSING ADMINISTRATION	0	20,638	1,094,794			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,085	0	844,210		14.00
15.00	01500	PHARMACY	0	31,423	0	0	1,407,749	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	44,992	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	15,747	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	516,253	111,172	369,260	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	59,457	27,581	91,610	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	12,677	42,105	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	72,373	257,128	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	29,600	98,317	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,367	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	27,880	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,414	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	20,361	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	17,212	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	844,210	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,407,749	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	8,674	0	0	0	76.00
76.01	03040	RADIATION ONCOLOGY	0	28,899	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	219,600	0	0	0	90.00
90.01	09001	WOUND CARE	0	3,853	0	0	0	90.01
91.00	09100	EMERGENCY	0	71,165	236,374	0	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	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	575,710	845,713	1,094,794	844,210	1,407,749	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	25,687	0	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	0	64,006	0	0	0	194.05
194.06	07956	THE ARBORS	53,306	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	848	0	0	0	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	0	3,216	0	0	0	194.10
194.11	07960	SPORTS HEALTH	0	0	0	0	0	194.11
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)	629,016	939,470	1,094,794	844,210	1,407,749	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 4/1/2019 4:24 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,090,946					16.00
17.00	01700	SOCIAL SERVICE	0	602,217				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	122,514	288,813	6,641,239	0	6,641,239	30.00
31.00	03100	INTENSIVE CARE UNIT	22,137	52,329	1,527,138	0	1,527,138	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	17,568	82,640	710,547	0	710,547	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	397,349	0	5,347,268	0	5,347,268	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	41,023	0	1,588,232	0	1,588,232	52.00
53.00	05300	ANESTHESIOLOGY	31,360	0	220,001	0	220,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	169,146	0	3,410,249	0	3,410,249	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	249,942	0	3,727,020	0	3,727,020	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	15,214	0	157,659	0	157,659	63.00
65.00	06500	RESPIRATORY THERAPY	82,274	0	1,257,718	0	1,257,718	65.00
66.00	06600	PHYSICAL THERAPY	48,283	0	1,394,497	0	1,394,497	66.00
69.00	06900	ELECTROCARDIOLOGY	44,808	0	881,825	0	881,825	69.00
69.01	06901	CARDIAC REHAB	7,839	0	839,725	0	839,725	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,216,731	0	2,216,731	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,698,552	0	1,698,552	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	9,408,364	0	9,408,364	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	134,101	0	737,049	0	737,049	76.00
76.01	03040	RADIATION ONCOLOGY	105,240	0	1,542,640	0	1,542,640	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	183,013	25,164	7,363,187	0	7,363,187	90.00
90.01	09001	WOUND CARE	37,402	0	409,767	0	409,767	90.01
91.00	09100	EMERGENCY	202,772	153,271	4,120,942	0	4,120,942	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,911,985	602,217	55,200,350	0	55,200,350	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	12,342	0	12,342	194.00
194.01	07951	MOB	0	0	210,246	0	210,246	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	0	1,184,205	0	1,184,205	194.04
194.05	07955	PHYSICIANS OFFICE	173,002	0	11,740,760	0	11,740,760	194.05
194.06	07956	THE ARBORS	0	0	53,306	0	53,306	194.06
194.07	07957	PAIN MANAGEMENT	5,129	0	274,574	0	274,574	194.07
194.08	07958	OPS	0	0	243,952	0	243,952	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	148,977	0	148,977	194.09
194.10	07961	RHEUMATOLOGY	830	0	341,008	0	341,008	194.10
194.11	07960	SPORTS HEALTH	0	0	183,386	0	183,386	194.11
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)	2,090,946	602,217	69,593,106	0	69,593,106	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 4/1/2019 4:24 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS MOB	CAPITAL RELATED COSTS OPS	CAPITAL RELATED COSTS Subtotal	
			0	1.00	1.01	1.02	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	42,664	0	0	42,664	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	367,004	21,160	0	388,164	5.00
7.00	00700	OPERATION OF PLANT	0	903,715	1,370	11,704	916,789	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,970	0	0	15,970	8.00
9.00	00900	HOUSEKEEPING	0	35,753	732	432	36,917	9.00
10.00	01000	DIETARY	0	146,674	0	0	146,674	10.00
11.00	01100	CAFETERIA	0	73,145	0	0	73,145	11.00
13.00	01300	NURSING ADMINISTRATION	0	56,740	0	0	56,740	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	105,622	0	0	105,622	14.00
15.00	01500	PHARMACY	0	53,822	0	0	53,822	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	190,540	0	0	190,540	16.00
17.00	01700	SOCIAL SERVICE	0	36,444	0	0	36,444	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	756,070	0	0	756,070	30.00
31.00	03100	INTENSIVE CARE UNIT	0	135,208	0	0	135,208	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	23,085	0	0	23,085	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	498,732	0	2,798	501,530	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	126,660	0	0	126,660	52.00
53.00	05300	ANESTHESIOLOGY	0	45,121	0	0	45,121	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	231,054	0	8,309	239,363	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	123,794	6,930	3,875	134,599	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	8,804	0	0	8,804	65.00
66.00	06600	PHYSICAL THERAPY	0	97,765	0	0	97,765	66.00
69.00	06900	ELECTROCARDIOLOGY	0	12,259	14,580	0	26,839	69.00
69.01	06901	CARDIAC REHAB	0	142,374	0	0	142,374	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	18,760	0	0	18,760	76.00
76.01	03040	RADIATION ONCOLOGY	0	0	0	48,216	48,216	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,375	87,349	0	92,724	90.00
90.01	09001	WOUND CARE	0	0	14,106	0	14,106	90.01
91.00	09100	EMERGENCY	0	392,111	0	0	392,111	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,645,265	146,227	75,334	4,866,826	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	38,285	0	38,285	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	58,480	0	0	58,480	194.04
194.05	07955	PHYSICIANS OFFICE	0	115,271	18,414	30,762	164,447	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	41,230	41,230	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	0	0	22,577	0	22,577	194.10
194.11	07960	SPORTS HEALTH	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,819,016	225,503	147,326	5,191,845	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 4/1/2019 4:24 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	42,664					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,721	392,885				5.00
7.00	00700	OPERATION OF PLANT	845	25,414	943,048			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,192	2,916	20,078		8.00
9.00	00900	HOUSEKEEPING	698	6,270	7,570	0	51,455	9.00
10.00	01000	DIETARY	149	2,829	26,779	0	0	10.00
11.00	01100	CAFETERIA	450	4,944	13,355	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	805	5,768	10,359	0	137	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	305	3,816	19,284	0	2,514	14.00
15.00	01500	PHARMACY	673	7,471	9,827	0	273	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	920	10,561	34,789	0	410	16.00
17.00	01700	SOCIAL SERVICE	417	3,131	6,654	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,458	23,270	138,045	5,010	17,770	30.00
31.00	03100	INTENSIVE CARE UNIT	756	6,146	24,686	580	2,733	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	373	2,914	4,215	1,385	164	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,301	22,371	93,511	6,619	6,149	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	871	7,274	23,125	0	916	52.00
53.00	05300	ANESTHESIOLOGY	0	843	8,238	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,392	16,305	49,470	1,390	2,186	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	18,639	32,284	0	957	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	804	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	777	6,280	1,607	0	1,230	65.00
66.00	06600	PHYSICAL THERAPY	227	6,990	17,850	113	547	66.00
69.00	06900	ELECTROCARDIOLOGY	468	4,039	15,462	0	1,230	69.00
69.01	06901	CARDIAC REHAB	430	3,899	25,994	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,748	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	9,589	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	45,166	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	283	3,263	3,425	0	0	76.00
76.01	03040	RADIATION ONCOLOGY	774	6,537	42,274	0	2,186	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,915	36,785	80,203	0	1,640	90.00
90.01	09001	WOUND CARE	162	1,650	12,794	0	683	90.01
91.00	09100	EMERGENCY	1,961	16,723	71,591	4,981	4,373	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,131	318,631	776,307	20,078	46,098	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	15	0	0	437	194.00
194.01	07951	MOB	0	251	34,723	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	695	6,184	10,677	0	547	194.04
194.05	07955	PHYSICIANS OFFICE	8,483	62,797	64,717	0	3,280	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	2	1,516	0	0	0	194.07
194.08	07958	OPS	0	265	36,148	0	1,093	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	64	841	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	179	1,350	20,476	0	0	194.10
194.11	07960	SPORTS HEALTH	110	1,035	0	0	0	194.11
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)	42,664	392,885	943,048	20,078	51,455	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 4/1/2019 4:24 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	176,431					10.00
11.00	01100	CAFETERIA	0	91,894				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,019	75,828			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,965	0	133,506		14.00
15.00	01500	PHARMACY	0	3,074	0	0	75,140	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,401	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,540	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	144,802	10,874	25,576	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	16,677	2,698	6,345	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	1,240	2,916	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,079	17,809	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,895	6,810	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,122	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,727	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	921	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,992	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	1,684	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	133,506	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	75,140	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	848	0	0	0	76.00
76.01	03040	RADIATION ONCOLOGY	0	2,827	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	21,478	0	0	0	90.00
90.01	09001	WOUND CARE	0	377	0	0	0	90.01
91.00	09100	EMERGENCY	0	6,961	16,372	0	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	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	161,479	82,722	75,828	133,506	75,140	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	2,513	0	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	0	6,261	0	0	0	194.05
194.06	07956	THE ARBORS	14,952	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	83	0	0	0	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	0	315	0	0	0	194.10
194.11	07960	SPORTS HEALTH	0	0	0	0	0	194.11
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)	176,431	91,894	75,828	133,506	75,140	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 4/1/2019 4:24 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241,621					16.00
17.00	01700	SOCIAL SERVICE	0	48,186				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,154	23,110	1,162,139	0	1,162,139	30.00
31.00	03100	INTENSIVE CARE UNIT	2,557	4,187	202,573	0	202,573	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	2,030	6,612	44,934	0	44,934	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,964	0	703,333	0	703,333	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,739	0	173,290	0	173,290	52.00
53.00	05300	ANESTHESIOLOGY	3,623	0	57,825	0	57,825	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,541	0	334,769	0	334,769	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	28,875	0	215,354	0	215,354	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,758	0	2,562	0	2,562	63.00
65.00	06500	RESPIRATORY THERAPY	9,505	0	30,930	0	30,930	65.00
66.00	06600	PHYSICAL THERAPY	5,578	0	129,991	0	129,991	66.00
69.00	06900	ELECTROCARDIOLOGY	5,177	0	55,207	0	55,207	69.00
69.01	06901	CARDIAC REHAB	906	0	175,287	0	175,287	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	141,254	0	141,254	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	9,589	0	9,589	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	120,306	0	120,306	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	15,492	0	42,071	0	42,071	76.00
76.01	03040	RADIATION ONCOLOGY	12,158	0	114,972	0	114,972	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	21,143	2,013	264,901	0	264,901	90.00
90.01	09001	WOUND CARE	4,321	0	34,093	0	34,093	90.01
91.00	09100	EMERGENCY	23,426	12,264	550,763	0	550,763	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	220,947	48,186	4,566,143	0	4,566,143	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	452	0	452	194.00
194.01	07951	MOB	0	0	73,259	0	73,259	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	0	79,096	0	79,096	194.04
194.05	07955	PHYSICIANS OFFICE	19,986	0	329,971	0	329,971	194.05
194.06	07956	THE ARBORS	0	0	14,952	0	14,952	194.06
194.07	07957	PAIN MANAGEMENT	592	0	2,193	0	2,193	194.07
194.08	07958	OPS	0	0	78,736	0	78,736	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	905	0	905	194.09
194.10	07961	RHEUMATOLOGY	96	0	44,993	0	44,993	194.10
194.11	07960	SPORTS HEALTH	0	0	1,145	0	1,145	194.11
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)	241,621	48,186	5,191,845	0	5,191,845	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 4/1/2019 4:24 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	188,294					1.00
1.01	00101	MOB	0	43,769				1.01
1.02	00102	OPS	0	0	27,643			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,667	0	0	32,297,321		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,340	4,107	0	3,573,780	-8,578,239	5.00
7.00	00700	OPERATION OF PLANT	35,311	266	2,196	639,692	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	624	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,397	142	81	528,712	0	9.00
10.00	01000	DIETARY	5,731	0	0	112,739	0	10.00
11.00	01100	CAFETERIA	2,858	0	0	340,560	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,217	0	0	609,609	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,127	0	0	230,992	0	14.00
15.00	01500	PHARMACY	2,103	0	0	509,667	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,445	0	0	696,528	0	16.00
17.00	01700	SOCIAL SERVICE	1,424	0	0	315,832	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,542	0	0	2,618,048	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,283	0	0	572,004	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	902	0	0	282,271	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,487	0	525	1,741,621	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,949	0	0	659,131	0	52.00
53.00	05300	ANESTHESIOLOGY	1,763	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,028	0	1,559	1,053,869	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,837	1,345	727	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	344	0	0	588,114	0	65.00
66.00	06600	PHYSICAL THERAPY	3,820	0	0	171,607	0	66.00
69.00	06900	ELECTROCARDIOLOGY	479	2,830	0	354,637	0	69.00
69.01	06901	CARDIAC REHAB	5,563	0	0	325,326	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	733	0	0	213,927	0	76.00
76.01	03040	RADIATION ONCOLOGY	0	0	9,047	586,117	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	210	16,954	0	6,749,202	0	90.00
90.01	09001	WOUND CARE	0	2,738	0	122,795	0	90.01
91.00	09100	EMERGENCY	15,321	0	0	1,484,155	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	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	181,505	28,382	14,135	25,080,935	-8,578,239	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	7,431	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	2,285	0	0	526,202	0	194.04
194.05	07955	PHYSICIANS OFFICE	4,504	3,574	5,772	6,421,959	0	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	1,306	0	194.07
194.08	07958	OPS	0	0	7,736	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	48,522	0	194.09
194.10	07961	RHEUMATOLOGY	0	4,382	0	135,206	0	194.10
194.11	07960	SPORTS HEALTH	0	0	0	83,191	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,819,016	225,503	147,326	11,707,047		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 4/1/2019 4:24 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
203.00		Unit cost multiplier (Wkst. B, Part I)	25.593041	5.152117	5.329595	0.362477		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				42,664		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.001321		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: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 4/1/2019 4:24 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	61,014,867					5.00
7.00	00700	OPERATION OF PLANT	3,946,878	201,819				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	185,180	624	280,838			8.00
9.00	00900	HOUSEKEEPING	973,808	1,620	0	7,531		9.00
10.00	01000	DIETARY	439,403	5,731	0	0	4,602	10.00
11.00	01100	CAFETERIA	767,775	2,858	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	895,725	2,217	0	20	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	592,698	4,127	0	368	0	14.00
15.00	01500	PHARMACY	1,160,208	2,103	0	40	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,640,155	7,445	0	60	0	16.00
17.00	01700	SOCIAL SERVICE	486,331	1,424	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,613,909	29,542	70,070	2,601	3,777	30.00
31.00	03100	INTENSIVE CARE UNIT	954,561	5,283	8,109	400	435	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	452,621	902	19,368	24	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,474,282	20,012	92,599	900	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,129,669	4,949	0	134	0	52.00
53.00	05300	ANESTHESIOLOGY	130,910	1,763	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,532,250	10,587	19,440	320	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,894,675	6,909	0	140	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	124,887	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	975,352	344	0	180	0	65.00
66.00	06600	PHYSICAL THERAPY	1,085,527	3,820	1,577	80	0	66.00
69.00	06900	ELECTROCARDIOLOGY	627,247	3,309	0	180	0	69.00
69.01	06901	CARDIAC REHAB	605,462	5,563	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,203,340	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,489,183	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,014,435	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	506,687	733	0	0	0	76.00
76.01	03040	RADIATION ONCOLOGY	1,015,232	9,047	0	320	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,712,819	17,164	0	240	0	90.00
90.01	09001	WOUND CARE	256,191	2,738	0	100	0	90.01
91.00	09100	EMERGENCY	2,597,151	15,321	69,675	640	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	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,484,551	166,135	280,838	6,747	4,212	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	2,276	0	0	64	0	194.00
194.01	07951	MOB	39,006	7,431	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	960,348	2,285	0	80	0	194.04
194.05	07955	PHYSICIANS OFFICE	9,750,842	13,850	0	480	0	194.05
194.06	07956	THE ARBORS	0	0	0	0	390	194.06
194.07	07957	PAIN MANAGEMENT	235,489	0	0	0	0	194.07
194.08	07958	OPS	41,230	7,736	0	160	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	130,614	0	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	209,730	4,382	0	0	0	194.10
194.11	07960	SPORTS HEALTH	160,781	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	8,578,239	4,501,781	225,134	1,146,855	629,016	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.140593	22.306032	0.801651	152.284557	136.683181	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	392,885	943,048	20,078	51,455	176,431	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 4/1/2019 4:24 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	
			5.00	7.00	8.00	9.00	10.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006439	4.672741	0.071493	6.832426	38.337897	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: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 4/1/2019 4:24 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS)	MEDICAL RECORDS & LIBRARY (REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	684,411					11.00
13.00	01300	NURSING ADMINISTRATION	15,035	240,122				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,632	0	100			14.00
15.00	01500	PHARMACY	22,892	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,777	0	0	0	160,713,368	16.00
17.00	01700	SOCIAL SERVICE	11,472	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	80,990	80,990	0	0	9,416,894	30.00
31.00	03100	INTENSIVE CARE UNIT	20,093	20,093	0	0	1,701,563	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	9,235	9,235	0	0	1,350,338	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,724	56,396	0	0	30,536,679	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,564	21,564	0	0	3,153,170	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,410,450	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,150	0	0	0	13,001,245	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	19,211,563	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	1,169,421	63.00
65.00	06500	RESPIRATORY THERAPY	20,311	0	0	0	6,323,935	65.00
66.00	06600	PHYSICAL THERAPY	6,858	0	0	0	3,711,210	66.00
69.00	06900	ELECTROCARDIOLOGY	14,833	0	0	0	3,444,141	69.00
69.01	06901	CARDIAC REHAB	12,539	0	0	0	602,525	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	6,319	0	0	0	10,307,567	76.00
76.01	03040	RADIATION ONCOLOGY	21,053	0	0	0	8,089,163	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	159,980	0	0	0	14,067,114	90.00
90.01	09001	WOUND CARE	2,807	0	0	0	2,874,876	90.01
91.00	09100	EMERGENCY	51,844	51,844	0	0	15,585,867	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	616,108	240,122	100	100	146,957,721	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	18,713	0	0	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	46,629	0	0	0	13,297,609	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	618	0	0	0	394,208	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	2,343	0	0	0	63,830	194.10
194.11	07960	SPORTS HEALTH	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	939,470	1,094,794	844,210	1,407,749	2,090,946	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.372669	4.559324	8,442.100000	14,077.490000	0.013010	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 4/1/2019 4:24 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS)	MEDICAL RECORDS & LIBRARY (REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	91,894	75,828	133,506	75,140	241,621	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.134267	0.315789	1,335.060000	751.400000	0.001503	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: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 4/1/2019 4:24 pm

		Cost Center Description	SOCIAL SERVICE (HOURS)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	MOB			1.01
1.02	00102	OPS			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	10,530		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,050		30.00
31.00	03100	INTENSIVE CARE UNIT	915		31.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
42.00	04200	SUBPROVIDER	0		42.00
43.00	04300	NURSERY	1,445		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		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
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0		59.00
60.00	06000	LABORATORY	0		60.00
60.01	06001	BLOOD LABORATORY	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		63.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
69.01	06901	CARDIAC REHAB	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0		76.00
76.01	03040	RADIATION ONCOLOGY	0		76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	440		90.00
90.01	09001	WOUND CARE	0		90.01
91.00	09100	EMERGENCY	2,680		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,530		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	FOUNDATION	0		194.00
194.01	07951	MOB	0		194.01
194.02	07952	NONREIMBURSABLE OTHER	0		194.02
194.03	07953	PIH	0		194.03
194.04	07954	HEALTH COMPANIES	0		194.04
194.05	07955	PHYSICIANS OFFICE	0		194.05
194.06	07956	THE ARBORS	0		194.06
194.07	07957	PAIN MANAGEMENT	0		194.07
194.08	07958	OPS	0		194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0		194.09
194.10	07961	RHEUMATOLOGY	0		194.10
194.11	07960	SPORTS HEALTH	0		194.11
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	602,217		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	57.190598		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	48,186		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 4/1/2019 4:24 pm

		Cost Center Description	SOCIAL SERVICE (HOURS)		
			17.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	4.576068		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: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 4/1/2019 4:24 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,641,239		6,641,239	0	6,641,239	30.00
31.00	03100	INTENSIVE CARE UNIT	1,527,138		1,527,138	0	1,527,138	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	710,547		710,547	0	710,547	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,347,268		5,347,268	0	5,347,268	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,588,232		1,588,232	0	1,588,232	52.00
53.00	05300	ANESTHESIOLOGY	220,001		220,001	0	220,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,410,249		3,410,249	0	3,410,249	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,727,020		3,727,020	0	3,727,020	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	157,659		157,659	0	157,659	63.00
65.00	06500	RESPIRATORY THERAPY	1,257,718	0	1,257,718	0	1,257,718	65.00
66.00	06600	PHYSICAL THERAPY	1,394,497	0	1,394,497	0	1,394,497	66.00
69.00	06900	ELECTROCARDIOLOGY	881,825		881,825	0	881,825	69.00
69.01	06901	CARDIAC REHAB	839,725		839,725	0	839,725	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,216,731		2,216,731	0	2,216,731	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,698,552		1,698,552	0	1,698,552	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,408,364		9,408,364	0	9,408,364	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	737,049		737,049	0	737,049	76.00
76.01	03040	RADIATION ONCOLOGY	1,542,640		1,542,640	0	1,542,640	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,363,187		7,363,187	24,719	7,387,906	90.00
90.01	09001	WOUND CARE	409,767		409,767	0	409,767	90.01
91.00	09100	EMERGENCY	4,120,942		4,120,942	0	4,120,942	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,454,314		1,454,314		1,454,314	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	56,654,664	0	56,654,664	24,719	56,679,383	200.00
201.00		Less Observation Beds	1,454,314		1,454,314		1,454,314	201.00
202.00		Total (see instructions)	55,200,350	0	55,200,350	24,719	55,225,069	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 4/1/2019 4:24 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,637,258		6,637,258			30.00
31.00	03100	INTENSIVE CARE UNIT	881,540		881,540			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,350,338		1,350,338			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,100,469	26,426,887	30,527,356	0.175163	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,158,543	532,626	2,691,169	0.590164	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	248,500	2,161,950	2,410,450	0.091270	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	811,532	12,136,990	12,948,522	0.263370	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	2,599,200	16,612,363	19,211,563	0.193999	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	589,928	838,993	1,428,921	0.110334	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	3,001,781	2,201,694	5,203,475	0.241707	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	388,473	3,322,737	3,711,210	0.375753	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	712,088	3,852,513	4,564,601	0.193188	0.000000	69.00
69.01	06901	CARDIAC REHAB	978	601,547	602,525	1.393677	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,295,875	5,151,218	6,447,093	0.343834	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,644,730	6,277,725	7,922,455	0.214397	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,993,373	39,510,327	43,503,700	0.216266	0.000000	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	704,992	7,695,698	8,400,690	0.087737	0.000000	76.00
76.01	03040	RADIATION ONCOLOGY	34,690	8,054,473	8,089,163	0.190705	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	38,900	1,872,272	1,911,172	3.852708	0.000000	90.00
90.01	09001	WOUND CARE	18,135	2,138,892	2,157,027	0.189968	0.000000	90.01
91.00	09100	EMERGENCY	1,557,268	13,970,729	15,527,997	0.265388	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	175,792	2,831,023	3,006,815	0.483673	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	32,944,383	156,190,657	189,135,040			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	32,944,383	156,190,657	189,135,040			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 4/1/2019 4:24 pm

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		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
41.00	04100	SUBPROVIDER - IRF	
42.00	04200	SUBPROVIDER	
43.00	04300	NURSERY	
44.00	04400	SKILLED NURSING FACILITY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.175163
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.590164
53.00	05300	ANESTHESIOLOGY	0.091270
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.263370
57.00	05700	CT SCAN	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0.000000
60.00	06000	LABORATORY	0.193999
60.01	06001	BLOOD LABORATORY	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.110334
65.00	06500	RESPIRATORY THERAPY	0.241707
66.00	06600	PHYSICAL THERAPY	0.375753
69.00	06900	ELECTROCARDIOLOGY	0.193188
69.01	06901	CARDIAC REHAB	1.393677
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.343834
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.214397
73.00	07300	DRUGS CHARGED TO PATIENTS	0.216266
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.087737
76.01	03040	RADIATION ONCOLOGY	0.190705
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	3.865642
90.01	09001	WOUND CARE	0.189968
91.00	09100	EMERGENCY	0.265388
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.483673
		OTHER REIMBURSABLE COST CENTERS	
95.00	09500	AMBULANCE SERVICES	0.000000
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 4/1/2019 4:24 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	6,641,239		6,641,239	0	6,641,239	30.00
31.00	03100	INTENSIVE CARE UNIT	1,527,138		1,527,138	0	1,527,138	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	710,547		710,547	0	710,547	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,347,268		5,347,268	0	5,347,268	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,588,232		1,588,232	0	1,588,232	52.00
53.00	05300	ANESTHESIOLOGY	220,001		220,001	0	220,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,410,249		3,410,249	0	3,410,249	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,727,020		3,727,020	0	3,727,020	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	157,659		157,659	0	157,659	63.00
65.00	06500	RESPIRATORY THERAPY	1,257,718	0	1,257,718	0	1,257,718	65.00
66.00	06600	PHYSICAL THERAPY	1,394,497	0	1,394,497	0	1,394,497	66.00
69.00	06900	ELECTROCARDIOLOGY	881,825		881,825	0	881,825	69.00
69.01	06901	CARDIAC REHAB	839,725		839,725	0	839,725	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,216,731		2,216,731	0	2,216,731	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,698,552		1,698,552	0	1,698,552	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,408,364		9,408,364	0	9,408,364	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	737,049		737,049	0	737,049	76.00
76.01	03040	RADIATION ONCOLOGY	1,542,640		1,542,640	0	1,542,640	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,363,187		7,363,187	24,719	7,387,906	90.00
90.01	09001	WOUND CARE	409,767		409,767	0	409,767	90.01
91.00	09100	EMERGENCY	4,120,942		4,120,942	0	4,120,942	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,454,314		1,454,314		1,454,314	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	56,654,664	0	56,654,664	24,719	56,679,383	200.00
201.00		Less Observation Beds	1,454,314		1,454,314		1,454,314	201.00
202.00		Total (see instructions)	55,200,350	0	55,200,350	24,719	55,225,069	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 4/1/2019 4:24 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	6,637,258		6,637,258			30.00
31.00	03100	INTENSIVE CARE UNIT	881,540		881,540			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,350,338		1,350,338			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,100,469	26,426,887	30,527,356	0.175163	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,158,543	532,626	2,691,169	0.590164	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	248,500	2,161,950	2,410,450	0.091270	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	811,532	12,136,990	12,948,522	0.263370	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	2,599,200	16,612,363	19,211,563	0.193999	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	589,928	838,993	1,428,921	0.110334	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	3,001,781	2,201,694	5,203,475	0.241707	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	388,473	3,322,737	3,711,210	0.375753	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	712,088	3,852,513	4,564,601	0.193188	0.000000	69.00
69.01	06901	CARDIAC REHAB	978	601,547	602,525	1.393677	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,295,875	5,151,218	6,447,093	0.343834	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,644,730	6,277,725	7,922,455	0.214397	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,993,373	39,510,327	43,503,700	0.216266	0.000000	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	704,992	7,695,698	8,400,690	0.087737	0.000000	76.00
76.01	03040	RADIATION ONCOLOGY	34,690	8,054,473	8,089,163	0.190705	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	38,900	1,872,272	1,911,172	3.852708	0.000000	90.00
90.01	09001	WOUND CARE	18,135	2,138,892	2,157,027	0.189968	0.000000	90.01
91.00	09100	EMERGENCY	1,557,268	13,970,729	15,527,997	0.265388	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	175,792	2,831,023	3,006,815	0.483673	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	32,944,383	156,190,657	189,135,040			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	32,944,383	156,190,657	189,135,040			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 4/1/2019 4:24 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
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		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
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHAB	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		76.00
76.01	03040	RADIATION ONCOLOGY	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND 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
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 4/1/2019 4:24 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,162,139	0	1,162,139	4,836	240.31	30.00
31.00	INTENSIVE CARE UNIT	202,573		202,573	435	465.69	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	44,934		44,934	1,044	43.04	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	1,409,646		1,409,646	6,315		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,668	400,837	30.00
31.00	INTENSIVE CARE UNIT	220	102,452	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	1,888	503,289	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 4/1/2019 4:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	703,333	30,527,356	0.023039	1,099,267	25,326	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	173,290	2,691,169	0.064392	12,434	801	52.00
53.00	05300	ANESTHESIOLOGY	57,825	2,410,450	0.023989	61,770	1,482	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	334,769	12,948,522	0.025854	496,962	12,848	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	215,354	19,211,563	0.011210	1,249,969	14,012	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,562	1,428,921	0.001793	227,056	407	63.00
65.00	06500	RESPIRATORY THERAPY	30,930	5,203,475	0.005944	1,725,176	10,254	65.00
66.00	06600	PHYSICAL THERAPY	129,991	3,711,210	0.035027	249,940	8,755	66.00
69.00	06900	ELECTROCARDIOLOGY	55,207	4,564,601	0.012095	422,861	5,115	69.00
69.01	06901	CARDIAC REHAB	175,287	602,525	0.290921	620	180	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	141,254	6,447,093	0.021910	526,830	11,543	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,589	7,922,455	0.001210	918,231	1,111	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	120,306	43,503,700	0.002765	1,821,639	5,037	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	42,071	8,400,690	0.005008	431,979	2,163	76.00
76.01	03040	RADIATION ONCOLOGY	114,972	8,089,163	0.014213	32,247	458	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	264,901	1,911,172	0.138607	16,668	2,310	90.00
90.01	09001	WOUND CARE	34,093	2,157,027	0.015806	8,092	128	90.01
91.00	09100	EMERGENCY	550,763	15,527,997	0.035469	993,695	35,245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	254,487	3,006,815	0.084637	47,220	3,997	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,410,984	180,265,904		10,342,656	141,172	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 4/1/2019 4:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,836	0.00	1,668	30.00
31.00	03100	INTENSIVE CARE UNIT		0	435	0.00	220	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00
43.00	04300	NURSERY		0	1,044	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	6,315		1,888	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 4/1/2019 4:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	76.00
76.01	03040	RADIATION ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND 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: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 4/1/2019 4:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	30,527,356	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,691,169	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,410,450	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,948,522	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	19,211,563	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,428,921	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,203,475	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,711,210	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,564,601	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	602,525	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,447,093	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	7,922,455	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	43,503,700	0.000000	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	8,400,690	0.000000	76.00
76.01	03040	RADIATION ONCOLOGY	0	0	0	8,089,163	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,911,172	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	2,157,027	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	15,527,997	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,006,815	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	180,265,904		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 4/1/2019 4:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,099,267	0	6,386,429	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	12,434	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	61,770	0	550,960	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	496,962	0	3,113,579	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,249,969	0	2,379,728	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	227,056	0	240,129	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,725,176	0	760,725	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	249,940	0	30,811	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	422,861	0	1,337,935	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	620	0	251,181	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	526,830	0	902,705	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	918,231	0	2,001,372	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,821,639	0	14,341,258	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	431,979	0	2,681,532	0	76.00
76.01	03040	RADIATION ONCOLOGY	0.000000	32,247	0	2,546,502	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	16,668	0	1,621,810	0	90.00
90.01	09001	WOUND CARE	0.000000	8,092	0	982,837	0	90.01
91.00	09100	EMERGENCY	0.000000	993,695	0	3,282,443	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	47,220	0	725,650	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		10,342,656	0	44,137,586	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 4/1/2019 4:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.175163	6,386,429	0	0	1,118,666	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.590164	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.091270	550,960	0	0	50,286	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.263370	3,113,579	0	0	820,023	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.193999	2,379,728	1,040	0	461,665	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.110334	240,129	0	0	26,494	63.00
65.00	06500	RESPIRATORY THERAPY	0.241707	760,725	0	0	183,873	65.00
66.00	06600	PHYSICAL THERAPY	0.375753	30,811	0	0	11,577	66.00
69.00	06900	ELECTROCARDIOLOGY	0.193188	1,337,935	0	0	258,473	69.00
69.01	06901	CARDIAC REHAB	1.393677	251,181	0	0	350,065	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.343834	902,705	0	0	310,381	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.214397	2,001,372	0	0	429,088	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.216266	14,341,258	320	84,687	3,101,527	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.087737	2,681,532	0	0	235,270	76.00
76.01	03040	RADIATION ONCOLOGY	0.190705	2,546,502	0	0	485,631	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3.852708	1,621,810	0	31	6,248,360	90.00
90.01	09001	WOUND CARE	0.189968	982,837	0	0	186,708	90.01
91.00	09100	EMERGENCY	0.265388	3,282,443	0	15	871,121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.483673	725,650	0	0	350,977	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		44,137,586	1,360	84,733	15,500,185	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		44,137,586	1,360	84,733	15,500,185	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 4/1/2019 4:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	202	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69	18,315		73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	0		76.00
76.01	03040	RADIATION ONCOLOGY	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	119		90.00
90.01	09001	WOUND CARE	0	0		90.01
91.00	09100	EMERGENCY	0	4		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)	271	18,438		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	271	18,438		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0072	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 4/1/2019 4:24 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,836	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,836	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)	3,777	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,668	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,641,239	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,641,239	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)	6,641,239	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)	1,373.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,290,648	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)	2,290,648	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 4/1/2019 4:24 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,527,138	435	3,510.66	220	772,345	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)	2,365,958	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,428,951	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)	503,289	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	141,172	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	644,461	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,784,490	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)	1,059	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,373.29	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,454,314	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 4/1/2019 4:24 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,162,139	6,641,239	0.174988	1,454,314	254,487	90.00
91.00	Nursing School cost	0	6,641,239	0.000000	1,454,314	0	91.00
92.00	Allied health cost	0	6,641,239	0.000000	1,454,314	0	92.00
93.00	All other Medical Education	0	6,641,239	0.000000	1,454,314	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 4/1/2019 4:24 pm

Title XIX | 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)	4,836	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,836	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)	3,777	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	182	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,044	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,641,239	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,641,239	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)	6,641,239	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)	1,373.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	249,939	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)	249,939	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 4/1/2019 4:24 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)	710,547	1,044	680.60	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,527,138	435	3,510.66	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	252,806	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	502,745	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)	1,059	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,373.29	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,454,314	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 4/1/2019 4:24 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	1,162,139	6,641,239	0.174988	1,454,314	254,487	90.00
91.00	Nursing School cost	0	6,641,239	0.000000	1,454,314	0	91.00
92.00	Allied health cost	0	6,641,239	0.000000	1,454,314	0	92.00
93.00	All other Medical Education	0	6,641,239	0.000000	1,454,314	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 4/1/2019 4:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,846,133		30.00
31.00	03100	INTENSIVE CARE UNIT		421,937		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.175163	1,099,267	192,551	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.590164	12,434	7,338	52.00
53.00	05300	ANESTHESIOLOGY	0.091270	61,770	5,638	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.263370	496,962	130,885	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.193999	1,249,969	242,493	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.110334	227,056	25,052	63.00
65.00	06500	RESPIRATORY THERAPY	0.241707	1,725,176	416,987	65.00
66.00	06600	PHYSICAL THERAPY	0.375753	249,940	93,916	66.00
69.00	06900	ELECTROCARDIOLOGY	0.193188	422,861	81,692	69.00
69.01	06901	CARDIAC REHAB	1.393677	620	864	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.343834	526,830	181,142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.214397	918,231	196,866	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.216266	1,821,639	393,959	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.087737	431,979	37,901	76.00
76.01	03040	RADIATION ONCOLOGY	0.190705	32,247	6,150	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.865642	16,668	64,433	90.00
90.01	09001	WOUND CARE	0.189968	8,092	1,537	90.01
91.00	09100	EMERGENCY	0.265388	993,695	263,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.483673	47,220	22,839	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)		10,342,656	2,365,958	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)		10,342,656		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 4/1/2019 4:24 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		228,675		30.00
31.00	03100	INTENSIVE CARE UNIT		14,946		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		66,318		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.175163	228,806	40,078	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.590164	181,558	107,149	52.00
53.00	05300	ANESTHESIOLOGY	0.091270	15,620	1,426	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.263370	16,202	4,267	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.193999	77,699	15,074	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.110334	26,539	2,928	63.00
65.00	06500	RESPIRATORY THERAPY	0.241707	68,525	16,563	65.00
66.00	06600	PHYSICAL THERAPY	0.375753	805	302	66.00
69.00	06900	ELECTROCARDIOLOGY	0.193188	9,287	1,794	69.00
69.01	06901	CARDIAC REHAB	1.393677	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.343834	66,883	22,997	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.214397	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.216266	119,212	25,782	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.087737	20,669	1,813	76.00
76.01	03040	RADIATION ONCOLOGY	0.190705	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.852708	0	0	90.00
90.01	09001	WOUND CARE	0.189968	0	0	90.01
91.00	09100	EMERGENCY	0.265388	37,878	10,052	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.483673	5,337	2,581	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)		875,020	252,806	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)		875,020		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0072 | Component CCN: 15-U072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 4/1/2019 4:24 pm

Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	0	0	76.00
76.01	03040	RADIATION ONCOLOGY	0.000000	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	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: 15-0072	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 4/1/2019 4:24 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	3,008,040	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	841,097	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	19,036	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	42.60	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.39	30.00
31.00	Percentage of Medicaid patient days (see instructions)	27.46	31.00
32.00	Sum of lines 30 and 31	31.85	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	115,474	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 4/1/2019 4:24 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000070470	0.000078327	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	476,849	630,477	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	356,657	158,915	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	515,572		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	4,499,219		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	5,966,225		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	5,966,225	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	310,787	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	6,277,012	59.00
60.00	Primary payer payments	7,839	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	6,269,173	61.00
62.00	Deductibles billed to program beneficiaries	683,232	62.00
63.00	Coinsurance billed to program beneficiaries	670	63.00
64.00	Allowable bad debts (see instructions)	33,561	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	21,815	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	33,561	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	5,607,086	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	4,537	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 4/1/2019 4:24 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2018	720,106	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2019	206,541	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,538,270	71.00
71.01	Sequestration adjustment (see instructions)		130,765	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		6,391,734	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		15,771	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		536,352	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 4/1/2019 4:24 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,008,040	0	3,008,040		3,008,040	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	841,097	0		841,097	841,097	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	19,036	0	19,036	0	19,036	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	115,474	0	90,241	25,233	115,474	11.00
11.01	Uncompensated care payments	36.00	515,572	0	356,657	158,915	515,572	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,499,219	0	3,473,974	1,025,245	4,499,219	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	5,966,225	0	4,668,391	1,297,834	5,966,225	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,966,225	0	4,668,391	1,297,834	5,966,225	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	310,787	0	243,423	67,364	310,787	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 4/1/2019 4:24 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	4,911,814	1,365,198	6,277,012	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	307,975	0	240,611	67,364	307,975	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	2,812	0	2,812	0	2,812	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	310,787	0	243,423	67,364	310,787	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.146607	0.151290		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			720,106		720,106	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				206,541	206,541	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 4/1/2019 4:24 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,008,040	3,008,040		3,008,040	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	841,097		841,097	841,097	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	19,036	19,036	0	19,036	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	115,474	90,241	25,233	115,474	11.00
11.01	Uncompensated care payments	36.00	515,572	356,657	158,915	515,572	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,499,219	3,473,974	1,025,245	4,499,219	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	5,966,225	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,966,225	5,966,225	0	5,966,225	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	310,787	243,423	67,364	310,787	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			6,209,648	67,364	6,277,012	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 4/1/2019 4:24 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	307,975	240,611	67,364	307,975	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	2,812	2,812	0	2,812	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	310,787	243,423	67,364	310,787	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	720,106	720,106		720,106	28.00
29.00	Low volume adjustment on or after October 1	70.97	206,541		206,541	206,541	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	4,537	1,145	3,392	4,537	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 4/1/2019 4:24 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	18,709	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	15,500,185	2.00
3.00	OPPS payments	10,235,425	3.00
4.00	Outlier payment (see instructions)	71,917	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)	18,709	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	86,093	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)	86,093	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)	86,093	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	67,384	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)	18,709	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)	10,307,342	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	208	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,145,832	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)	8,180,011	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)	8,180,011	30.00
31.00	Primary payer payments	2,701	31.00
32.00	Subtotal (line 30 minus line 31)	8,177,310	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)	108,750	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	70,688	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	112,302	36.00
37.00	Subtotal (see instructions)	8,247,998	37.00
38.00	MSP-LCC reconciliation amount from PS&R	10	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)	8,247,988	40.00
40.01	Sequestration adjustment (see instructions)	164,960	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	8,022,226	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	60,802	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: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 4/1/2019 4:24 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,391,734		8,022,226	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)		6,391,734		8,022,226	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		15,771		60,802	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,407,505		8,083,028	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: 15-0072 | Component CCN: 15-U072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 4/1/2019 4:24 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		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)		0		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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		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: 15-0072	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 4/1/2019 4:24 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-0072 | Component CCN: 15-U072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 4/1/2019 4:24 pm

Title XVIII | Swing Beds - SNF | PPS

		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	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)			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	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	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	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)	0	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)	0	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)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	0	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)	0	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: 15-0072 | Component CCN: 15-U072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 4/1/2019 4:24 pm

Title XIX | Swing Beds - SNF | PPS

		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: 15-0072	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 4/1/2019 4:24 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	502,745		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	502,745	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	502,745	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	309,939		8.00
9.00	Ancillary service charges	875,020	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,184,959	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,184,959	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	682,214	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	502,745	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	502,745	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	502,745	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	502,745	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	502,745	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	502,745	0	40.00
41.00	Interim payments	592,480	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-89,735	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 4/1/2019 4:24 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	24,128,912	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	39,283,586	0	0	0	4.00
5.00	Other receivable	1,895,622	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-27,842,679	0	0	0	6.00
7.00	Inventory	2,028,943	0	0	0	7.00
8.00	Prepaid expenses	953,581	0	0	0	8.00
9.00	Other current assets	177,500	0	0	0	9.00
10.00	Due from other funds	24,128	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	40,649,593	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	205,783	0	0	0	12.00
13.00	Land improvements	869,699	0	0	0	13.00
14.00	Accumulated depreciation	-410,084	0	0	0	14.00
15.00	Buildings	66,695,199	0	0	0	15.00
16.00	Accumulated depreciation	-38,538,339	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	7,616,441	0	0	0	19.00
20.00	Accumulated depreciation	-3,415,909	0	0	0	20.00
21.00	Automobiles and trucks	118,602	0	0	0	21.00
22.00	Accumulated depreciation	-102,906	0	0	0	22.00
23.00	Major movable equipment	40,375,498	0	0	0	23.00
24.00	Accumulated depreciation	-30,127,147	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)	43,286,837	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	12,928,995	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,928,995	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	96,865,425	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	9,612,304	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,269,573	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,018,134	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	-4,994,667	0	0	0	43.00
44.00	Other current liabilities	1,331,899	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,237,243	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	15,926,002	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,926,002	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	26,163,245	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	70,702,180				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)	70,702,180	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	96,865,425	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 4/1/2019 4:24 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		69,346,450		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,355,730				2.00
3.00	Total (sum of line 1 and line 2)		70,702,180		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)		70,702,180		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)		70,702,180		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: 15-0072 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 4/1/2019 4:24 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,987,653		7,987,653	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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	0		0	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)	7,987,653		7,987,653	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	881,540		881,540	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)	881,540		881,540	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,869,193		8,869,193	17.00
18.00	Ancillary services	22,284,535	135,077,609	157,362,144	18.00
19.00	Outpatient services	1,760,655	21,143,048	22,903,703	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN CLINICS	0	14,906,590	14,906,590	27.00
27.01	PROFESSIONAL FEES	855,288	12,573,219	13,428,507	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	33,769,671	183,700,466	217,470,137	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		82,721,241		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)		82,721,241		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0072	Period: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 4/1/2019 4:24 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	217,470,137	1.00
2.00	Less contractual allowances and discounts on patients' accounts	135,475,383	2.00
3.00	Net patient revenues (line 1 minus line 2)	81,994,754	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	82,721,241	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-726,487	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,957,400	24.00
24.01	INVESTMENT INCOME	8,206	24.01
24.02	GAIN ON SALE OF EQUIPMENT	1,475	24.02
24.03	OTHER NON OPERATING REVENUE	115,136	24.03
25.00	Total other income (sum of lines 6-24)	2,082,217	25.00
26.00	Total (line 5 plus line 25)	1,355,730	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)	1,355,730	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0072	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 4/1/2019 4:24 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	307,975	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	2,812	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	12.26	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	310,787	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00