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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1310	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 4/27/2020 11:05 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 4/27/2020 Time: 11:05 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PARKVIEW WABASH HOSPITAL, INC. (15-1310) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) JEANNE WICKENS
Officer or Administrator of Provider(s)

SVP/CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-358,295	796,062	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-38,171	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-396,466	796,062	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 4/27/2020 11:05 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 10 JOHN KISSINGER DR	PO Box:			1.00
2.00	City: WABASH	State: IN	Zip Code: 46992	County: WABASH	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	PARKVIEW WABASH HOSPITAL, INC.	151310	99915	1	12/17/2001	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PARKVIEW WABASH HOSPITAL SWING BEDS	15Z310	99915		12/17/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 4/27/2020 11:05 am

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				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: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 4/27/2020 11:05 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 4/27/2020 11:05 am

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1310	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 4/27/2020 11:05 am

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	66,729	0	76,612	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 4/27/2020 11:05 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: WISCONSIN PHYSICIANS SERVICE	Contractor's Number: 08101	141.00
142.00	Street: 10501 CORPORATE DRIVE	PO Box: 5600		142.00
143.00	City: FORT WAYNE	State: IN	Zip Code: 46845	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)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 4/27/2020 11:05 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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	03/27/2019	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.			Y	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.			Y	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	04/30/2019	Y	05/01/2019	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 4/27/2020 11:05 am

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC	NICKESON	41.00
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALTH SYSTEM, INC.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	2603738406	ERIC.NICKESON@PARKVIEW.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1310	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 4/27/2020 11:05 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 4/27/2020 11:05 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	18	7,809	64,320.00	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)		18	7,809	64,320.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		18	7,809	64,320.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			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)		18				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 4/27/2020 11:05 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,143	27	2,599			1.00
2.00	HMO and other (see instructions)	807	34				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	30	0	30			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	11			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,173	27	2,640			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		14	40			13.00
14.00	Total (see instructions)	1,173	41	2,680	0.00	186.30	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						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	186.30	27.00
28.00	Observation Bed Days		7	1,128			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			6			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	19			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: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 4/27/2020 11:05 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	432	15	1,018	1.00
2.00	HMO and other (see instructions)			280	19		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	432	15	1,018	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					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 RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 4/27/2020 11:05 am

		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	233,716	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,146,988	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	2,098	6.00
7.00	Employee Managed Care Program Administration Fees	32,880	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,567,054	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	26,187	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)	59,342	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	14,308	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	908,138	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	58,372	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	34,651	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,083,734	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 4/27/2020 11:05 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	5,083,734	1.00
2.00	Hospital	0	5,083,734	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	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: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 4/27/2020 11:05 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.297077	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	492,539	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	7,449,371	6.00
7.00	Medicaid cost (line 1 times line 6)	2,213,037	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,720,498	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)	1,064,383	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	10,142,589	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	3,013,130	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)	1,948,747	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)	3,669,245	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)	1,407,846	468,625	1,876,471	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	418,239	468,625	886,864	21.00
22.00	Payments received from patients for amounts previously written off as charity care	9,793	11,496	21,289	22.00
23.00	Cost of charity care (line 21 minus line 22)	408,446	457,129	865,575	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)	3,875,383	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	636,630	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	979,431	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,895,952	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,203,122	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,068,697	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,737,942	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 4/27/2020 11:05 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		6,279,801	6,279,801	-649,938	5,629,863	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,227,824	1,227,824	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	72,687	4,412,932	4,485,619	-2,200	4,483,419	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	775,759	13,995,817	14,771,576	-73,305	14,698,271	5.00
7.00	00700	OPERATION OF PLANT	302,360	1,005,272	1,307,632	-1,336	1,306,296	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	251,455	261,103	512,558	0	512,558	9.00
10.00	01000	DIETARY	500,047	366,170	866,217	-693,032	173,185	10.00
11.00	01100	CAFETERIA	0	0	0	687,313	687,313	11.00
13.00	01300	NURSING ADMINISTRATION	307,997	21,860	329,857	-1,917	327,940	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	695,032	510,773	1,205,805	-277,937	927,868	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,720,639	1,420,841	3,141,480	-699,743	2,441,737	30.00
43.00	04300	NURSERY	0	0	0	142,495	142,495	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	642,679	761,684	1,404,363	-100,169	1,304,194	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	555,482	555,482	52.00
53.00	05300	ANESTHESIOLOGY	0	18	18	0	18	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	829,579	829,762	1,659,341	-2,072	1,657,269	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	1,558,639	1,558,639	0	1,558,639	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	987,093	131,788	1,118,881	-312,308	806,573	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	132,236	132,236	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	94,337	94,337	68.00
69.00	06900	ELECTROCARDIOLOGY	467,593	54,513	522,106	-4,159	517,947	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	927,521	927,521	-493,633	433,888	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	493,633	493,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,104,771	3,104,771	277,546	3,382,317	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	199	199	0	199	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	131,522	131,522	5,719	137,241	90.00
90.01	09001	SENIOR CARE	127,921	101,708	229,629	0	229,629	90.01
91.00	09100	EMERGENCY	609,517	2,698,407	3,307,924	-2,718	3,305,206	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	185,072	185,072	0	185,072	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		302,118	302,118	-302,118	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,290,358	39,062,291	47,352,649	0	47,352,649	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37,971	6,559	44,530	0	44,530	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	125,554	117,163	242,717	0	242,717	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	1,722,419	1,722,419	0	1,722,419	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	1,395,061	1,395,061	0	1,395,061	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	1,219,099	1,219,099	0	1,219,099	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	-635,044	-635,044	0	-635,044	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	49,802	49,802	0	49,802	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	8,453,883	42,937,350	51,391,233	0	51,391,233	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 4/27/2020 11:05 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-4,018,269	1,611,594		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-18,122	1,209,702		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,324,916	3,158,503		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,225,248	11,473,023		5.00
7.00	00700	OPERATION OF PLANT	-349,248	957,048		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	512,558		9.00
10.00	01000	DIETARY	-3,247	169,938		10.00
11.00	01100	CAFETERIA	0	687,313		11.00
13.00	01300	NURSING ADMINISTRATION	0	327,940		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-298,686	629,182		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-368,967	2,072,770		30.00
43.00	04300	NURSERY	0	142,495		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,304,194		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	555,482		52.00
53.00	05300	ANESTHESIOLOGY	0	18		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-143,243	1,514,026		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	1,558,639		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	806,573		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	132,236		67.00
68.00	06800	SPEECH PATHOLOGY	0	94,337		68.00
69.00	06900	ELECTROCARDIOLOGY	0	517,947		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	433,888		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	493,633		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,382,317		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	199		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	137,241		90.00
90.01	09001	SENIOR CARE	0	229,629		90.01
91.00	09100	EMERGENCY	-669,436	2,635,770		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-185,072	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,604,454	36,748,195		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-5,995	38,535		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	242,717		192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	1,722,419		192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	1,395,061		192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	1,219,099		192.03
194.00	07950	FITNESS CENTER	0	0		194.00
194.01	07951	FOUNDATION	635,044	0		194.01
194.02	07952	NEW DIRECTION	0	0		194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	49,802		194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0		194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,975,405	41,415,828		200.00

RECLASSIFICATIONS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 4/27/2020 11:05 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - REHAB THERAPY RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	115,150	17,086	1.00
2.00	SPEECH PATHOLOGY	68.00	82,148	12,189	2.00
	0		197,298	29,275	
	B - CLINIC DIETICIAN				
1.00	CLINIC	90.00	5,719	0	1.00
	0		5,719	0	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	394,839	292,474	1.00
	0		394,839	292,474	
	D - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	277,546	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	277,546	
	E - SALARY RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	3,244,607	0	1.00
	0		3,244,607	0	
	G - DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,076,567	1.00
	0		0	1,076,567	
	H - EQUIP & BLDG LEASE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	78,650	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	130,389	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	0		0	209,039	
	I - IMPLANTABLE MEDICAL SUP.				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	493,633	1.00
	0		0	493,633	
	K - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	302,118	1.00
	0		0	302,118	
	L - INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	45,861	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	20,868	2.00
	0		0	66,729	
	M - OB RECLASS				
1.00	NURSERY	43.00	31,982	110,513	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	124,675	430,807	2.00
	TOTALS		156,657	541,320	
500.00	Grand Total: Increases		3,999,120	3,288,701	500.00

RECLASSIFICATIONS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 4/27/2020 11:05 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - REHAB THERAPY RECLASS						
1.00	PHYSICAL THERAPY	66.00	197,298	29,275	0		1.00
2.00		0.00	0	0	0		2.00
	0		197,298	29,275			
	B - CLINIC DIETICIAN						
1.00	DIETARY	10.00	5,719	0	0		1.00
	0		5,719	0			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	394,839	292,474	0		1.00
	0		394,839	292,474			
	D - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	276,020	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	701	0		2.00
3.00	OPERATING ROOM	50.00	0	712	0		3.00
4.00	EMERGENCY	91.00	0	113	0		4.00
	0		0	277,546			
	E - SALARY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,244,607	0		1.00
	0		0	3,244,607			
	G - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,076,567	9		1.00
	0		0	1,076,567			
	H - EQUIP & BLDG LEASE						
1.00	PHYSICAL THERAPY	66.00	0	78,650	10		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,371	10		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,200	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	6,576	0		4.00
5.00	OPERATION OF PLANT	7.00	0	1,336	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	1,917	0		6.00
7.00	PHARMACY	15.00	0	1,917	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	1,766	0		8.00
9.00	OPERATING ROOM	50.00	0	99,457	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	4,159	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	7,085	0		11.00
12.00	EMERGENCY	91.00	0	2,605	0		12.00
	0		0	209,039			
	I - IMPLANTABLE MEDICAL SUP.						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	493,633	0		1.00
	0		0	493,633			
	K - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	302,118	11		1.00
	0		0	302,118			
	L - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	66,729	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	66,729			
	M - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	156,657	541,320	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		156,657	541,320			
500.00	Grand Total: Decreases		754,513	6,533,308			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 4/27/2020 11:05 am

		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	1,295,014	223,467	0	223,467	0	1.00
2.00	Land Improvements	314,699	717,763	0	717,763	0	2.00
3.00	Buildings and Fixtures	12,586,529	31,615,598	0	31,615,598	0	3.00
4.00	Building Improvements	4,150,859	0	0	0	0	4.00
5.00	Fixed Equipment	921,093	1,841,777	0	1,841,777	0	5.00
6.00	Movable Equipment	14,498,443	8,760,627	0	8,760,627	0	6.00
7.00	HIT designated Assets	2,301,368	45,148	0	45,148	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,068,005	43,204,380	0	43,204,380	0	8.00
9.00	Reconciling Items	309,317	243,404	0	243,404	0	9.00
10.00	Total (line 8 minus line 9)	35,758,688	42,960,976	0	42,960,976	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,518,481	0	1.00
2.00	Land Improvements	1,032,462	294,327	2.00
3.00	Buildings and Fixtures	44,202,127	12,527,725	3.00
4.00	Building Improvements	4,150,859	2,849,352	4.00
5.00	Fixed Equipment	2,762,870	699,975	5.00
6.00	Movable Equipment	23,259,070	12,177,132	6.00
7.00	HIT designated Assets	2,346,516	1,821,935	7.00
8.00	Subtotal (sum of lines 1-7)	79,272,385	30,370,446	8.00
9.00	Reconciling Items	552,721	0	9.00
10.00	Total (line 8 minus line 9)	78,719,664	30,370,446	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II Date/Time Prepared: 4/27/2020 11:05 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	6,279,801	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,279,801	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	6,279,801		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	6,279,801		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 4/27/2020 11:05 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	53,666,800	0	53,666,800	0.697643	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,259,070	0	23,259,070	0.302357	0	2.00
3.00	Total (sum of lines 1-2)	76,925,870	0	76,925,870	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,184,965	78,650	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,058,445	130,389	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,243,410	209,039	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	302,118	45,861	0	0	1,611,594	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	20,868	0	0	1,209,702	2.00
3.00	Total (sum of lines 1-2)	302,118	66,729	0	0	2,821,296	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 4/27/2020 11:05 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-675,589			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,798,567			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	0	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	B	-298,686	PHARMACY	15.00	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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.02
20.00	Vending machines	B	-211,649	OPERATION OF PLANT	7.00	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	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-4,018,269	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 4/27/2020 11:05 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	DEPRECIATION - - HIT ASSETS 2016	A	-7,956	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	DEPRECIATION - - HIT ASSETS PRIOR	A	-139,872	ADMINISTRATIVE & GENERAL	5.00	0	33.01
34.00	RECRUITMENT	A	-1,076	ADMINISTRATIVE & GENERAL	5.00	0	34.00
38.00	SELF INSURANCE ADJUSTMENT	A	-1,324,167	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	LOBBYING	A	-4,288	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	MARKETING	A	-158	ADMINISTRATIVE & GENERAL	5.00	0	40.00
40.01	TELEVISION SERVICE	A	-5,955	OPERATION OF PLANT	7.00	0	40.01
42.00	LIQUOR ADJUSTMENT	A	-696	ADMINISTRATIVE & GENERAL	5.00	0	42.00
42.01	LIQUOR ADJUSTMENT	A	-10	DIETARY	10.00	0	42.01
42.02	TELEVISION	A	-18,122	CAP REL COSTS-MVBLE EQUIP	2.00	9	42.02
44.00	EMS ADJUSTMENT	A	-178,919	AMBULANCE SERVICES	95.00	0	44.00
45.00	TELEMETRY MONITORING	A	25,033	ADULTS & PEDIATRICS	30.00	0	45.00
45.01	FITNESS CENTER	B	-749	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.01
45.02	PURCHASING DISCOUNTS	A	-30,667	ADMINISTRATIVE & GENERAL	5.00	0	45.02
46.01	HHH ADJUSTMENT	A	-22,284	ADMINISTRATIVE & GENERAL	5.00	0	46.01
48.00	OTHER OPERATING REV	A	-113,573	RADIOLOGY-DIAGNOSTIC	54.00	0	48.00
49.00	OTHER OPERATING REV	A	-3,237	DIETARY	10.00	0	49.00
49.01	OTHER OPERATING REV	A	-5,995	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	49.01
49.02	HEARTSMART SCAN READS	A	-29,670	RADIOLOGY-DIAGNOSTIC	54.00	0	49.02
49.03	HAF FEE EXPENSE ADJUSTMENT	A	-1,219,684	ADMINISTRATIVE & GENERAL	5.00	0	49.03
49.04	HOSPITALIST AVAILABILITY COVERAGE	A	-394,000	ADULTS & PEDIATRICS	30.00	0	49.04
49.05	PHYSICIAN CLINIC RENT OFFSET	B	-131,644	OPERATION OF PLANT	7.00	0	49.05
49.06	REMOVE FOUNDATION REVENUE	A	635,044	FOUNDATION	194.01	0	49.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,975,405				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 4/27/2020 11:05 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	9,186,502	5,817,000	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY SUBSIDY (PPG)	0	4,578,133	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST EXPENSE ELIMINAT	0	589,936	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,186,502	10,985,069	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	PARKVIEW HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1310	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 4/27/2020 11:05 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	3,369,502	0		1.00
2.00	-4,578,133	0		2.00
3.00	-589,936	0		3.00
4.00	0	0		4.00
5.00	-1,798,567			5.00

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

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

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

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

6.00	HEALTH SYSTEM		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 4/27/2020 11:05 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	DR. A	13,333	0	13,333	0	0	1.00
2.00	91.00	DR. B	1,777,931	669,436	1,108,495	0	0	2.00
3.00	90.01	DR. C	31,219	0	31,219	0	0	3.00
4.00	90.01	DR. D	5,500	0	5,500	0	0	4.00
5.00	95.00	DR. E	6,153	6,153	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,834,136	675,589	1,158,547		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	DR. A	0	0	0	0	0	1.00
2.00	91.00	DR. B	0	0	0	0	0	2.00
3.00	90.01	DR. C	0	0	0	0	0	3.00
4.00	90.01	DR. D	0	0	0	0	0	4.00
5.00	95.00	DR. E	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	DR. A	0	0	0	0		1.00
2.00	91.00	DR. B	0	0	0	669,436		2.00
3.00	90.01	DR. C	0	0	0	0		3.00
4.00	90.01	DR. D	0	0	0	0		4.00
5.00	95.00	DR. E	0	0	0	6,153		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	675,589		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 4/27/2020 11:05 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,611,594	1,611,594				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,209,702		1,209,702			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,158,503	34,602	25,973	3,219,078		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,473,023	509,100	382,142	1,113,199	13,477,464	5.00
7.00	00700	OPERATION OF PLANT	957,048	104,719	78,605	83,721	1,224,093	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	512,558	36,878	27,681	69,626	646,743	9.00
10.00	01000	DIETARY	169,938	61,570	46,216	27,548	305,272	10.00
11.00	01100	CAFETERIA	687,313	44,368	33,304	109,327	874,312	11.00
13.00	01300	NURSING ADMINISTRATION	327,940	20,195	15,159	85,282	448,576	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	629,182	82,195	61,698	192,448	965,523	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,072,770	173,332	130,107	433,053	2,809,262	30.00
43.00	04300	NURSERY	142,495	932	699	8,856	152,982	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,304,194	159,212	119,508	177,952	1,760,866	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	555,482	7,616	5,716	34,521	603,335	52.00
53.00	05300	ANESTHESIOLOGY	18	1,541	1,157	0	2,716	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,514,026	120,542	90,482	229,703	1,954,753	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	1,558,639	58,291	43,755	0	1,660,685	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	806,573	8,476	6,362	218,687	1,040,098	66.00
67.00	06700	OCCUPATIONAL THERAPY	132,236	0	0	31,884	164,120	67.00
68.00	06800	SPEECH PATHOLOGY	94,337	0	0	22,746	117,083	68.00
69.00	06900	ELECTROCARDIOLOGY	517,947	58,685	44,051	129,472	750,155	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	433,888	0	0	0	433,888	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	493,633	0	0	0	493,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,382,317	0	0	0	3,382,317	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	199	0	0	0	199	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	137,241	1,021	767	1,584	140,613	90.00
90.01	09001	SENIOR CARE	229,629	22,327	16,759	35,420	304,135	90.01
91.00	09100	EMERGENCY	2,635,770	75,708	56,829	168,770	2,937,077	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,748,195	1,581,310	1,186,970	3,173,799	36,649,900	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,535	10,734	8,057	10,514	67,840	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	242,717	0	0	34,765	277,482	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	1,722,419	0	0	0	1,722,419	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	1,395,061	0	0	0	1,395,061	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	1,219,099	0	0	0	1,219,099	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	7,221	5,421	0	12,642	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	49,802	950	713	0	51,465	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	11,379	8,541	0	19,920	194.05
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)	41,415,828	1,611,594	1,209,702	3,219,078	41,415,828	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 4/27/2020 11:05 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,477,464					5.00
7.00	00700	OPERATION OF PLANT	590,502	1,814,595				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	311,989	62,608	0	1,021,340		9.00
10.00	01000	DIETARY	147,263	104,529	0	60,936	618,000	10.00
11.00	01100	CAFETERIA	421,768	75,324	0	43,911	0	11.00
13.00	01300	NURSING ADMINISTRATION	216,393	34,285	0	19,987	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	465,768	139,544	0	81,349	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,355,188	294,271	0	171,548	618,000	30.00
43.00	04300	NURSERY	73,799	1,582	0	922	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	849,442	270,297	0	157,573	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	291,049	12,929	0	7,537	0	52.00
53.00	05300	ANESTHESIOLOGY	1,310	2,616	0	1,525	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	942,973	204,647	0	119,301	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	801,114	95,828	0	55,864	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	501,743	196,920	0	114,797	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	79,171	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	56,481	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	361,875	99,631	0	58,081	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	209,308	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	238,129	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,631,627	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	96	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	67,832	1,734	0	1,011	0	90.00
90.01	09001	SENIOR CARE	146,715	37,905	0	22,097	0	90.01
91.00	09100	EMERGENCY	1,416,846	128,532	0	74,929	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,178,381	1,763,182	0	991,368	618,000	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	32,726	18,223	0	10,623	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	133,857	0	0	0	0	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	830,895	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	672,977	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	588,093	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	6,099	12,260	0	7,147	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	24,827	1,612	0	940	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	9,609	19,318	0	11,262	0	194.05
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)	13,477,464	1,814,595	0	1,021,340	618,000	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 4/27/2020 11:05 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,415,315					11.00
13.00	01300	NURSING ADMINISTRATION	53,652	772,893				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	122,223	0	0	1,774,407		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	393,062	393,567	0	46,316	0	30.00
43.00	04300	NURSERY	0	11,016	0	9	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	141,445	161,047	0	2,237	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	42,935	0	28	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,983	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	215,324	0	0	13,797	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	179,748	0	0	23,130	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,485	0	0	2,293	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,054	0	0	602	0	68.00
69.00	06900	ELECTROCARDIOLOGY	107,160	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,665,948	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,291	0	0	0	0	90.00
90.01	09001	SENIOR CARE	30,556	0	0	0	0	90.01
91.00	09100	EMERGENCY	144,315	164,328	0	18,064	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,415,315	772,893	0	1,774,407	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,415,315	772,893	0	1,774,407	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 4/27/2020 11:05 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,081,214	0	6,081,214		30.00
43.00	04300	NURSERY	240,310	0	240,310		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,342,907	0	3,342,907		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	957,813	0	957,813		52.00
53.00	05300	ANESTHESIOLOGY	10,150	0	10,150		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,450,795	0	3,450,795		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	2,613,491	0	2,613,491		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
66.00	06600	PHYSICAL THERAPY	2,056,436	0	2,056,436		66.00
67.00	06700	OCCUPATIONAL THERAPY	259,069	0	259,069		67.00
68.00	06800	SPEECH PATHOLOGY	187,220	0	187,220		68.00
69.00	06900	ELECTROCARDIOLOGY	1,376,902	0	1,376,902		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	643,196	0	643,196		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	731,762	0	731,762		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,679,892	0	6,679,892		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	295	0	295		76.98
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	212,481	0	212,481		90.00
90.01	09001	SENIOR CARE	541,408	0	541,408		90.01
91.00	09100	EMERGENCY	4,884,091	0	4,884,091		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		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,269,432	0	34,269,432		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	129,412	0	129,412		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	411,339	0	411,339		192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	2,553,314	0	2,553,314		192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	2,068,038	0	2,068,038		192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	1,807,192	0	1,807,192		192.03
194.00	07950	FITNESS CENTER	0	0	0		194.00
194.01	07951	FOUNDATION	38,148	0	38,148		194.01
194.02	07952	NEW DIRECTION	0	0	0		194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	78,844	0	78,844		194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.04
194.05	07955	OCCUPATIONAL HEALTH	60,109	0	60,109		194.05
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	41,415,828	0	41,415,828		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 4/27/2020 11:05 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	34,602	25,973	60,575	60,575	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	935,779	509,100	382,142	1,827,021	20,951	5.00
7.00	00700	OPERATION OF PLANT	0	104,719	78,605	183,324	1,575	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	36,878	27,681	64,559	1,310	9.00
10.00	01000	DIETARY	0	61,570	46,216	107,786	518	10.00
11.00	01100	CAFETERIA	0	44,368	33,304	77,672	2,057	11.00
13.00	01300	NURSING ADMINISTRATION	0	20,195	15,159	35,354	1,605	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	82,195	61,698	143,893	3,621	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	173,332	130,107	303,439	8,148	30.00
43.00	04300	NURSERY	0	932	699	1,631	167	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	159,212	119,508	278,720	3,348	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,616	5,716	13,332	650	52.00
53.00	05300	ANESTHESIOLOGY	0	1,541	1,157	2,698	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	120,542	90,482	211,024	4,322	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	58,291	43,755	102,046	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	8,476	6,362	14,838	4,115	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	600	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	428	68.00
69.00	06900	ELECTROCARDIOLOGY	0	58,685	44,051	102,736	2,436	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,021	767	1,788	30	90.00
90.01	09001	SENIOR CARE	0	22,327	16,759	39,086	666	90.01
91.00	09100	EMERGENCY	0	75,708	56,829	132,537	3,176	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	935,779	1,581,310	1,186,970	3,704,059	59,723	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,734	8,057	18,791	198	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	654	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	7,221	5,421	12,642	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	950	713	1,663	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	11,379	8,541	19,920	0	194.05
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)	935,779	1,611,594	1,209,702	3,757,075	60,575	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 4/27/2020 11:05 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,847,972					5.00
7.00	00700	OPERATION OF PLANT	80,968	265,867				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	42,779	9,173	0	117,821		9.00
10.00	01000	DIETARY	20,192	15,315	0	7,030	150,841	10.00
11.00	01100	CAFETERIA	57,831	11,036	0	5,066	0	11.00
13.00	01300	NURSING ADMINISTRATION	29,671	5,023	0	2,306	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	63,865	20,445	0	9,384	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	185,819	43,117	0	19,792	150,841	30.00
43.00	04300	NURSERY	10,119	232	0	106	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	116,472	39,603	0	18,177	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,908	1,894	0	869	0	52.00
53.00	05300	ANESTHESIOLOGY	180	383	0	176	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	129,297	29,984	0	13,762	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	109,846	14,040	0	6,444	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	68,797	28,852	0	13,243	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,856	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,744	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	49,619	14,598	0	6,700	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,700	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,651	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	223,713	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	13	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,301	254	0	117	0	90.00
90.01	09001	SENIOR CARE	20,117	5,554	0	2,549	0	90.01
91.00	09100	EMERGENCY	194,273	18,832	0	8,644	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,532,731	258,335	0	114,365	150,841	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,487	2,670	0	1,225	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,354	0	0	0	0	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	113,929	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	92,276	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	80,637	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	836	1,796	0	824	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	3,404	236	0	108	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	1,318	2,830	0	1,299	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,847,972	265,867	0	117,821	150,841	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 4/27/2020 11:05 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	153,662					11.00
13.00	01300	NURSING ADMINISTRATION	5,825	79,784				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	13,270	0	0	254,478		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,677	40,627	0	6,642	0	30.00
43.00	04300	NURSERY	0	1,137	0	1	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,357	16,625	0	321	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,432	0	4	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	284	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,378	0	0	1,979	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	19,515	0	0	3,317	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,464	0	0	329	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,417	0	0	86	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,634	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	238,924	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	140	0	0	0	0	90.00
90.01	09001	SENIOR CARE	3,317	0	0	0	0	90.01
91.00	09100	EMERGENCY	15,668	16,963	0	2,591	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	153,662	79,784	0	254,478	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
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)	153,662	79,784	0	254,478	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 4/27/2020 11:05 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	801,102	0	801,102		30.00
43.00	04300	NURSERY	13,393	0	13,393		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	488,623	0	488,623		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	61,089	0	61,089		52.00
53.00	05300	ANESTHESIOLOGY	3,721	0	3,721		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	413,746	0	413,746		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	232,376	0	232,376		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
66.00	06600	PHYSICAL THERAPY	152,677	0	152,677		66.00
67.00	06700	OCCUPATIONAL THERAPY	13,249	0	13,249		67.00
68.00	06800	SPEECH PATHOLOGY	9,675	0	9,675		68.00
69.00	06900	ELECTROCARDIOLOGY	187,723	0	187,723		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,700	0	28,700		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,651	0	32,651		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	462,637	0	462,637		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	13	0	13		76.98
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	11,630	0	11,630		90.00
90.01	09001	SENIOR CARE	71,289	0	71,289		90.01
91.00	09100	EMERGENCY	392,684	0	392,684		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		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,376,978	0	3,376,978		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,371	0	27,371		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,008	0	19,008		192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	113,929	0	113,929		192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	92,276	0	92,276		192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	80,637	0	80,637		192.03
194.00	07950	FITNESS CENTER	0	0	0		194.00
194.01	07951	FOUNDATION	16,098	0	16,098		194.01
194.02	07952	NEW DIRECTION	0	0	0		194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	5,411	0	5,411		194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.04
194.05	07955	OCCUPATIONAL HEALTH	25,367	0	25,367		194.05
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,757,075	0	3,757,075		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 4/27/2020 11:05 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	89,937					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		89,937				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,931	1,931	11,625,803			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,411	28,411	4,020,366	-13,477,464	27,938,364	5.00
7.00	00700	OPERATION OF PLANT	5,844	5,844	302,360	0	1,224,093	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,058	2,058	251,455	0	646,743	9.00
10.00	01000	DIETARY	3,436	3,436	99,489	0	305,272	10.00
11.00	01100	CAFETERIA	2,476	2,476	394,839	0	874,312	11.00
13.00	01300	NURSING ADMINISTRATION	1,127	1,127	307,997	0	448,576	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	4,587	4,587	695,032	0	965,523	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,673	9,673	1,563,982	0	2,809,262	30.00
43.00	04300	NURSERY	52	52	31,982	0	152,982	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,885	8,885	642,679	0	1,760,866	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	425	425	124,675	0	603,335	52.00
53.00	05300	ANESTHESIOLOGY	86	86	0	0	2,716	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,727	6,727	829,579	0	1,954,753	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	3,253	3,253	0	0	1,660,685	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	473	473	789,795	0	1,040,098	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	115,150	0	164,120	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	82,148	0	117,083	68.00
69.00	06900	ELECTROCARDIOLOGY	3,275	3,275	467,593	0	750,155	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	433,888	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	493,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,382,317	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	199	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	57	57	5,719	0	140,613	90.00
90.01	09001	SENIOR CARE	1,246	1,246	127,921	0	304,135	90.01
91.00	09100	EMERGENCY	4,225	4,225	609,517	0	2,937,077	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,247	88,247	11,462,278	-13,477,464	23,172,436	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	599	599	37,971	0	67,840	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	125,554	0	277,482	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	1,722,419	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	1,395,061	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	1,219,099	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	403	403	0	0	12,642	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	53	53	0	0	51,465	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	635	635	0	0	19,920	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,611,594	1,209,702	3,219,078		13,477,464	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.919143	13.450549	0.276891		0.482400	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			60,575		1,847,972	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.005210		0.066145	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 4/27/2020 11:05 am

	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 4/27/2020 11:05 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	59,648					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0				8.00
9.00	00900	HOUSEKEEPING	2,058	0	57,590			9.00
10.00	01000	DIETARY	3,436	0	3,436	2,711		10.00
11.00	01100	CAFETERIA	2,476	0	2,476	0	9,866	11.00
13.00	01300	NURSING ADMINISTRATION	1,127	0	1,127	0	374	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	4,587	0	4,587	0	852	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,673	0	9,673	2,711	2,740	30.00
43.00	04300	NURSERY	52	0	52	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,885	0	8,885	0	986	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	425	0	425	0	0	52.00
53.00	05300	ANESTHESIOLOGY	86	0	86	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,727	0	6,727	0	1,501	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	3,150	0	3,150	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	6,473	0	6,473	0	1,253	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	94	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	91	68.00
69.00	06900	ELECTROCARDIOLOGY	3,275	0	3,275	0	747	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	57	0	57	0	9	90.00
90.01	09001	SENIOR CARE	1,246	0	1,246	0	213	90.01
91.00	09100	EMERGENCY	4,225	0	4,225	0	1,006	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,958	0	55,900	2,711	9,866	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	599	0	599	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	403	0	403	0	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	53	0	53	0	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	635	0	635	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,814,595	0	1,021,340	618,000	1,415,315	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.421724	0.000000	17.734676	227.960162	143.453781	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	265,867	0	117,821	150,841	153,662	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.457266	0.000000	2.045859	55.640354	15.574904	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: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 4/27/2020 11:05 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REV)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	98,719					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	0	0	188,795			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	50,269	0	4,928	0		30.00
43.00	04300	NURSERY	1,407	0	1	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,570	0	238	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,484	0	3	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	211	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,468	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	0	2,461	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	244	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	64	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	177,255	0		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	SENIOR CARE	0	0	0	0		90.01
91.00	09100	EMERGENCY	20,989	0	1,922	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		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,719	0	188,795	0		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0		192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0		192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0		192.03
194.00	07950	FITNESS CENTER	0	0	0	0		194.00
194.01	07951	FOUNDATION	0	0	0	0		194.01
194.02	07952	NEW DIRECTION	0	0	0	0		194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0		194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0		194.05
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)	772,893	0	1,774,407	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.829222	0.000000	9.398591	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	79,784	0	254,478	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.808193	0.000000	1.347906	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Hospital | Cost

		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	6,081,214		6,081,214	0	0	30.00
43.00	04300	NURSERY	240,310		240,310	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,342,907		3,342,907	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	957,813		957,813	0	0	52.00
53.00	05300	ANESTHESIOLOGY	10,150		10,150	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,450,795		3,450,795	0	0	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
60.00	06000	LABORATORY	2,613,491		2,613,491	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	2,056,436	0	2,056,436	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	259,069	0	259,069	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	187,220	0	187,220	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,376,902		1,376,902	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	643,196		643,196	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	731,762		731,762	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,679,892		6,679,892	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	295		295	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	212,481		212,481	0	0	90.00
90.01	09001	SENIOR CARE	541,408		541,408	0	0	90.01
91.00	09100	EMERGENCY	4,884,091		4,884,091	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,825,363		1,825,363		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	36,094,795	0	36,094,795	0	0	200.00
201.00		Less Observation Beds	1,825,363		1,825,363		0	201.00
202.00		Total (see instructions)	34,269,432	0	34,269,432	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,725,294		4,725,294			30.00
43.00	04300	NURSERY	59,610		59,610			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	931,218	9,379,832	10,311,050	0.324206	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	232,374	0	232,374	4.121860	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	123,395	1,364,532	1,487,927	0.006822	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,275,401	25,729,557	27,004,958	0.127784	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
60.00	06000	LABORATORY	1,562,227	13,512,143	15,074,370	0.173373	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	223,052	3,412,611	3,635,663	0.565629	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	139,164	205,965	345,129	0.750644	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	33,691	108,513	142,204	1.316559	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,327,489	3,188,452	4,515,941	0.304898	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	223,484	1,733,335	1,956,819	0.328695	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	180,782	2,439,365	2,620,147	0.279283	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,731,552	19,009,217	21,740,769	0.307252	0.000000	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,337	0	1,337	0.220643	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	963,934	963,934	0.220431	0.000000	90.00
90.01	09001	SENIOR CARE	0	626,114	626,114	0.864712	0.000000	90.01
91.00	09100	EMERGENCY	804,441	17,218,027	18,022,468	0.271000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,889,316	1,889,316	0.966150	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	14,574,511	100,780,913	115,355,424			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,574,511	100,780,913	115,355,424			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
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
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	SENIOR CARE	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 4/27/2020 11:05 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,081,214		6,081,214	0	6,081,214	30.00
43.00	04300	NURSERY	240,310		240,310	0	240,310	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,342,907		3,342,907	0	3,342,907	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	957,813		957,813	0	957,813	52.00
53.00	05300	ANESTHESIOLOGY	10,150		10,150	0	10,150	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,450,795		3,450,795	0	3,450,795	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
60.00	06000	LABORATORY	2,613,491		2,613,491	0	2,613,491	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	2,056,436	0	2,056,436	0	2,056,436	66.00
67.00	06700	OCCUPATIONAL THERAPY	259,069	0	259,069	0	259,069	67.00
68.00	06800	SPEECH PATHOLOGY	187,220	0	187,220	0	187,220	68.00
69.00	06900	ELECTROCARDIOLOGY	1,376,902		1,376,902	0	1,376,902	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	643,196		643,196	0	643,196	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	731,762		731,762	0	731,762	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,679,892		6,679,892	0	6,679,892	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	295		295	0	295	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	212,481		212,481	0	212,481	90.00
90.01	09001	SENIOR CARE	541,408		541,408	0	541,408	90.01
91.00	09100	EMERGENCY	4,884,091		4,884,091	0	4,884,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,825,363		1,825,363		1,825,363	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	36,094,795	0	36,094,795	0	36,094,795	200.00
201.00		Less Observation Beds	1,825,363		1,825,363		1,825,363	201.00
202.00		Total (see instructions)	34,269,432	0	34,269,432	0	34,269,432	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 4/27/2020 11:05 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,725,294		4,725,294			30.00
43.00	04300	NURSERY	59,610		59,610			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	931,218	9,379,832	10,311,050	0.324206	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	232,374	0	232,374	4.121860	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	123,395	1,364,532	1,487,927	0.006822	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,275,401	25,729,557	27,004,958	0.127784	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
60.00	06000	LABORATORY	1,562,227	13,512,143	15,074,370	0.173373	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	223,052	3,412,611	3,635,663	0.565629	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	139,164	205,965	345,129	0.750644	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	33,691	108,513	142,204	1.316559	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,327,489	3,188,452	4,515,941	0.304898	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	223,484	1,733,335	1,956,819	0.328695	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	180,782	2,439,365	2,620,147	0.279283	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,731,552	19,009,217	21,740,769	0.307252	0.000000	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,337	0	1,337	0.220643	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	963,934	963,934	0.220431	0.000000	90.00
90.01	09001	SENIOR CARE	0	626,114	626,114	0.864712	0.000000	90.01
91.00	09100	EMERGENCY	804,441	17,218,027	18,022,468	0.271000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,889,316	1,889,316	0.966150	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	14,574,511	100,780,913	115,355,424			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,574,511	100,780,913	115,355,424			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 4/27/2020 11:05 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.324206		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4.121860		52.00
53.00	05300	ANESTHESIOLOGY	0.006822		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127784		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.173373		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
66.00	06600	PHYSICAL THERAPY	0.565629		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.750644		67.00
68.00	06800	SPEECH PATHOLOGY	1.316559		68.00
69.00	06900	ELECTROCARDIOLOGY	0.304898		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.328695		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.279283		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307252		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.220643		76.98
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.220431		90.00
90.01	09001	SENIOR CARE	0.864712		90.01
91.00	09100	EMERGENCY	0.271000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.966150		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part II Date/Time Prepared: 4/27/2020 11:05 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,342,907	488,623	2,854,284	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	957,813	61,089	896,724	0	0	52.00
53.00	05300	ANESTHESIOLOGY	10,150	3,721	6,429	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,450,795	413,746	3,037,049	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	2,613,491	232,376	2,381,115	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	2,056,436	152,677	1,903,759	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	259,069	13,249	245,820	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	187,220	9,675	177,545	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,376,902	187,723	1,189,179	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	643,196	28,700	614,496	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	731,762	32,651	699,111	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,679,892	462,637	6,217,255	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	295	13	282	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	212,481	11,630	200,851	0	0	90.00
90.01	09001	SENIOR CARE	541,408	71,289	470,119	0	0	90.01
91.00	09100	EMERGENCY	4,884,091	392,684	4,491,407	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,825,363	240,462	1,584,901	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	29,773,271	2,802,945	26,970,326	0	0	200.00
201.00		Less Observation Beds	1,825,363	240,462	1,584,901	0	0	201.00
202.00		Total (line 200 minus line 201)	27,947,908	2,562,483	25,385,425	0	0	202.00

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

Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part II Date/Time Prepared: 4/27/2020 11:05 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,342,907	10,311,050	0.324206		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	957,813	232,374	4.121860		52.00
53.00	05300	ANESTHESIOLOGY	10,150	1,487,927	0.006822		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,450,795	27,004,958	0.127784		54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
60.00	06000	LABORATORY	2,613,491	15,074,370	0.173373		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000		63.00
66.00	06600	PHYSICAL THERAPY	2,056,436	3,635,663	0.565629		66.00
67.00	06700	OCCUPATIONAL THERAPY	259,069	345,129	0.750644		67.00
68.00	06800	SPEECH PATHOLOGY	187,220	142,204	1.316559		68.00
69.00	06900	ELECTROCARDIOLOGY	1,376,902	4,515,941	0.304898		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	643,196	1,956,819	0.328695		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	731,762	2,620,147	0.279283		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,679,892	21,740,769	0.307252		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	295	1,337	0.220643		76.98
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	212,481	963,934	0.220431		90.00
90.01	09001	SENIOR CARE	541,408	626,114	0.864712		90.01
91.00	09100	EMERGENCY	4,884,091	18,022,468	0.271000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,825,363	1,889,316	0.966150		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	29,773,271	110,570,520			200.00
201.00		Less Observation Beds	1,825,363	0			201.00
202.00		Total (line 200 minus line 201)	27,947,908	110,570,520			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	488,623	10,311,050	0.047388	175,248	8,305	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	61,089	232,374	0.262891	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,721	1,487,927	0.002501	17,203	43	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	413,746	27,004,958	0.015321	405,325	6,210	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
60.00	06000	LABORATORY	232,376	15,074,370	0.015415	568,914	8,770	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
66.00	06600	PHYSICAL THERAPY	152,677	3,635,663	0.041994	101,664	4,269	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,249	345,129	0.038389	61,204	2,350	67.00
68.00	06800	SPEECH PATHOLOGY	9,675	142,204	0.068036	13,455	915	68.00
69.00	06900	ELECTROCARDIOLOGY	187,723	4,515,941	0.041569	601,078	24,986	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,700	1,956,819	0.014667	105,006	1,540	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,651	2,620,147	0.012462	22,028	275	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	462,637	21,740,769	0.021280	1,019,479	21,695	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	13	1,337	0.009723	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,630	963,934	0.012065	0	0	90.00
90.01	09001	SENIOR CARE	71,289	626,114	0.113859	0	0	90.01
91.00	09100	EMERGENCY	392,684	18,022,468	0.021789	49,263	1,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	240,462	1,889,316	0.127275	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,802,945	110,570,520		3,139,867	80,431	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	10,311,050	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	232,374	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,487,927	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	27,004,958	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	15,074,370	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,635,663	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	345,129	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	142,204	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,515,941	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,956,819	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,620,147	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,740,769	0.000000	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	1,337	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	963,934	0.000000	90.00
90.01	09001	SENIOR CARE	0	0	0	626,114	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	18,022,468	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,889,316	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	110,570,520		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	175,248	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	17,203	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	405,325	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	568,914	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.000000	101,664	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	61,204	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	13,455	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	601,078	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	105,006	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	22,028	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,019,479	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	49,263	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		3,139,867	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.324206	0	0	2,100,847	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4.121860	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.006822	0	0	295,420	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127784	0	0	7,804,010	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.173373	0	0	4,046,120	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.565629	0	0	1,191,800	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.750644	0	0	51,995	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.316559	0	0	37,211	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.304898	0	0	1,099,607	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.328695	0	0	310,012	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.279283	0	0	628,868	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307252	0	0	7,640,577	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.220643	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.220431	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.864712	0	0	384,900	0	90.01
91.00	09100	EMERGENCY	0.271000	0	0	3,718,117	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.966150	0	0	590,933	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	29,900,417	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	29,900,417	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	681,107		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	2,015		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	997,228		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	701,488		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	674,117		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	39,030		67.00
68.00	06800	SPEECH PATHOLOGY	0	48,990		68.00
69.00	06900	ELECTROCARDIOLOGY	0	335,268		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	101,899		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	175,632		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,347,583		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SENIOR CARE	0	332,828		90.01
91.00	09100	EMERGENCY	0	1,007,610		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	570,930		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	8,015,725		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	8,015,725		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.324206	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4.121860	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.006822	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127784	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.173373	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.565629	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.750644	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.316559	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.304898	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.328695	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.279283	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307252	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.220643	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.220431	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.864712	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.271000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.966150	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
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
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SENIOR CARE	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 4/27/2020 11:05 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	801,102	6,397	794,705	3,727	213.23	30.00
43.00	NURSERY	13,393		13,393	40	334.83	43.00
200.00	Total (lines 30 through 199)	814,495		808,098	3,767		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	27	5,757				30.00
43.00	NURSERY	14	4,688				43.00
200.00	Total (lines 30 through 199)	41	10,445				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 4/27/2020 11:05 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	488,623	10,311,050	0.047388	35,333	1,674	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	61,089	232,374	0.262891	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,721	1,487,927	0.002501	5,112	13	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	413,746	27,004,958	0.015321	40,084	614	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
60.00	06000	LABORATORY	232,376	15,074,370	0.015415	42,466	655	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
66.00	06600	PHYSICAL THERAPY	152,677	3,635,663	0.041994	860	36	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,249	345,129	0.038389	858	33	67.00
68.00	06800	SPEECH PATHOLOGY	9,675	142,204	0.068036	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	187,723	4,515,941	0.041569	9,878	411	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,700	1,956,819	0.014667	4,872	71	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,651	2,620,147	0.012462	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	462,637	21,740,769	0.021280	84,237	1,793	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	13	1,337	0.009723	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,630	963,934	0.012065	0	0	90.00
90.01	09001	SENIOR CARE	71,289	626,114	0.113859	0	0	90.01
91.00	09100	EMERGENCY	392,684	18,022,468	0.021789	20,138	439	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	240,523	1,889,316	0.127307	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,803,006	110,570,520		243,838	5,739	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 4/27/2020 11:05 am

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,727	0.00	27	30.00
43.00	04300	NURSERY		0	40	0.00	14	43.00
200.00		Total (lines 30 through 199)		0	3,767		41	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
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 4/27/2020 11:05 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 4/27/2020 11:05 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	10,311,050	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	232,374	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,487,927	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	27,004,958	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	15,074,370	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,635,663	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	345,129	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	142,204	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,515,941	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,956,819	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,620,147	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,740,769	0.000000	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	1,337	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	963,934	0.000000	90.00
90.01	09001	SENIOR CARE	0	0	0	626,114	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	18,022,468	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,889,316	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	110,570,520		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 4/27/2020 11:05 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	35,333	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	5,112	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	40,084	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	42,466	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.000000	860	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	858	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	9,878	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,872	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	84,237	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	20,138	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		243,838	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 4/27/2020 11:05 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.324206	0	0	82,156	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4.121860	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.006822	0	0	10,934	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127784	0	0	253,868	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.173373	0	0	300,906	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.565629	0	0	23,035	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.750644	0	0	1,379	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.316559	0	0	7,135	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.304898	0	0	8,815	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.328695	0	0	16,789	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.279283	0	0	6,460	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307252	0	0	234,954	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.220643	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.220431	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.864712	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.271000	0	0	277,848	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.966150	0	0	12,124	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	0	1,236,403	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	1,236,403	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 4/27/2020 11:05 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	26,635		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	75		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,440		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	52,169		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	13,029		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,035		67.00
68.00	06800	SPEECH PATHOLOGY	0	9,394		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,688		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,518		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,804		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	72,190		73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SENIOR CARE	0	0		90.01
91.00	09100	EMERGENCY	0	75,297		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	11,714		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	303,988		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	303,988		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,768	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,727	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,599	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	30	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	11	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)	1,143	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)	30	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,081,214	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)	1,511	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)	50,058	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,031,156	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)	6,031,156	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)	1,618.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,849,637	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,849,637	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	879,042	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,728,679	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)	48,547	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)	48,547	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)	1,128	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,618.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,825,363	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	801,102	6,081,214	0.131734	1,825,363	240,462	90.00
91.00	Nursing School cost	0	6,081,214	0.000000	1,825,363	0	91.00
92.00	Allied health cost	0	6,081,214	0.000000	1,825,363	0	92.00
93.00	All other Medical Education	0	6,081,214	0.000000	1,825,363	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1310	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 4/27/2020 11:05 am
	Title XIX	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,768	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,727	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,599	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	30	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	11	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)	27	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)	40	15.00
16.00	Nursery days (title V or XIX only)	14	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,081,214	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)	48,559	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,032,655	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)	6,032,655	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)	1,618.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	43,703	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)	43,703	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 4/27/2020 11:05 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	240,310	40	6,007.75	14	84,109	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	61,056	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	188,868	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)	10,445	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	5,739	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	16,184	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	172,684	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)	1,128	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,618.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,825,826	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 4/27/2020 11:05 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	801,102	6,081,214	0.131734	1,825,826	240,523	90.00
91.00	Nursing School cost	0	6,081,214	0.000000	1,825,826	0	91.00
92.00	Allied health cost	0	6,081,214	0.000000	1,825,826	0	92.00
93.00	All other Medical Education	0	6,081,214	0.000000	1,825,826	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,989,009		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.324206	175,248	56,816	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4.121860	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.006822	17,203	117	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127784	405,325	51,794	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
60.00	06000	LABORATORY	0.173373	568,914	98,634	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.565629	101,664	57,504	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.750644	61,204	45,942	67.00
68.00	06800	SPEECH PATHOLOGY	1.316559	13,455	17,714	68.00
69.00	06900	ELECTROCARDIOLOGY	0.304898	601,078	183,267	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.328695	105,006	34,515	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.279283	22,028	6,152	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307252	1,019,479	313,237	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.220643	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.220431	0	0	90.00
90.01	09001	SENIOR CARE	0.864712	0	0	90.01
91.00	09100	EMERGENCY	0.271000	49,263	13,350	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.966150	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)		3,139,867	879,042	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)		3,139,867		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		43,133		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.324206	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4.121860	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.006822	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127784	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
60.00	06000	LABORATORY	0.173373	7,598	1,317	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.565629	17,811	10,074	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.750644	13,900	10,434	67.00
68.00	06800	SPEECH PATHOLOGY	1.316559	946	1,245	68.00
69.00	06900	ELECTROCARDIOLOGY	0.304898	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.328695	10,157	3,339	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.279283	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307252	3,119	958	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.220643	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.220431	0	0	90.00
90.01	09001	SENIOR CARE	0.864712	0	0	90.01
91.00	09100	EMERGENCY	0.271000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.966150	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)		53,531	27,367	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)		53,531		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 4/27/2020 11:05 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		57,489		30.00
43.00	04300	NURSERY		4,820		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.324206	35,333	11,455	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4.121860	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.006822	5,112	35	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127784	40,084	5,122	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
60.00	06000	LABORATORY	0.173373	42,466	7,362	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.565629	860	486	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.750644	858	644	67.00
68.00	06800	SPEECH PATHOLOGY	1.316559	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.304898	9,878	3,012	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.328695	4,872	1,601	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.279283	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307252	84,237	25,882	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.220643	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.220431	0	0	90.00
90.01	09001	SENIOR CARE	0.864712	0	0	90.01
91.00	09100	EMERGENCY	0.271000	20,138	5,457	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.966150	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)		243,838	61,056	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)		243,838		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1310	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 4/27/2020 11:05 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,015,725	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	8,015,725	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	8,095,882	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	68,033	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,170,223	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)	2,857,626	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)	2,857,626	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,857,626	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)	958,699	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	623,154	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	914,129	36.00
37.00	Subtotal (see instructions)	3,480,780	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,480,780	40.00
40.01	Sequestration adjustment (see instructions)	69,616	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,615,102	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	796,062	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: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,604,937		2,556,402	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	04/11/2018	40,500	04/11/2018	58,700	3.01
3.02		08/30/2018	64,700		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)		105,200		58,700	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)		2,710,137		2,615,102	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		796,062	6.01
6.02	SETTLEMENT TO PROGRAM		358,295		0	6.02
7.00	Total Medicare program liability (see instructions)		2,351,842		3,411,164	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: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		113,311		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)		113,311		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		38,171		0	6.02
7.00	Total Medicare program liability (see instructions)		75,140		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: 15-1310	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 4/27/2020 11:05 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 4/27/2020 11:05 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	49,032	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)	27,641	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	30	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)	76,673	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	76,673	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)	76,673	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)	76,673	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)	76,673	0	19.00
19.01	Sequestration adjustment (see instructions)	1,533	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	113,311	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)	-38,171	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	Provider CCN: 15-1310	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 4/27/2020 11:05 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,728,679	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,728,679	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,755,966	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,755,966	19.00
20.00	Deductibles (exclude professional component)	369,603	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,386,363	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,386,363	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	20,732	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	13,476	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	16,712	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,399,839	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,399,839	30.00
30.01	Sequestration adjustment (see instructions)	47,997	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	2,710,137	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-358,295	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 4/27/2020 11:05 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	870,280	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	18,393,748	0	0	0	4.00
5.00	Other receivable	-431,197	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,654,451	0	0	0	6.00
7.00	Inventory	778,933	0	0	0	7.00
8.00	Prepaid expenses	56,776	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-40,424,849	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	-31,410,760	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,208,757	0	0	0	12.00
13.00	Land improvements	726,113	0	0	0	13.00
14.00	Accumulated depreciation	-39,567	0	0	0	14.00
15.00	Buildings	52,285,898	0	0	0	15.00
16.00	Accumulated depreciation	-21,467,125	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	1,959,604	0	0	0	19.00
20.00	Accumulated depreciation	-199,401	0	0	0	20.00
21.00	Automobiles and trucks	23,431	0	0	0	21.00
22.00	Accumulated depreciation	-23,430	0	0	0	22.00
23.00	Major movable equipment	11,931,807	0	0	0	23.00
24.00	Accumulated depreciation	-3,135,330	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)	43,270,757	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	318,100	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	322,765	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	640,865	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	12,500,862	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,835,824	0	0	0	37.00
38.00	Salaries, wages, and fees payable	583,624	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,048,751	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,468,199	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	24,139,016	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	24,139,016	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,607,215	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-16,106,353				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)	-16,106,353	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	12,500,862	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 4/27/2020 11:05 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-7,903,445		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8,792,844				2.00
3.00	Total (sum of line 1 and line 2)		-16,696,289		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)		-16,696,289		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)		-16,696,289		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: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 4/27/2020 11:05 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,448,200		4,448,200	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	24,940		24,940	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,473,140		4,473,140	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,473,140		4,473,140	17.00
18.00	Ancillary services	10,271,498	0	10,271,498	18.00
19.00	Outpatient services	0	107,573,801	107,573,801	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	FUTURE RHCS (PHYS CLINICS)	0	4,923,852	4,923,852	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,744,638	112,497,653	127,242,291	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		51,391,233		29.00
30.00	BAD DEBT	3,874,736			30.00
31.00	HOME OFFICE INTEREST EXPENSE	589,936			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)		4,464,672		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)		55,855,905		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 4/27/2020 11:05 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	127,242,291	1.00
2.00	Less contractual allowances and discounts on patients' accounts	81,183,907	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,058,384	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	55,855,905	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-9,797,521	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	10,352	6.00
7.00	Income from investments	111,353	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	139,079	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	214,163	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	298,686	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	5,995	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	181,307	22.00
23.00	Governmental appropriations	0	23.00
24.00	GAIN ON DISPOSAL OF ASSETS	1,091	24.00
24.01	COUNTY REIMBURSEMENT AMBULANCE SVC	32,904	24.01
24.02	MISC	1,181	24.02
24.03	MISC FROM PHYS OFFICES (FUTURE RHCS)	8,566	24.03
25.00	Total other income (sum of lines 6-24)	1,004,677	25.00
26.00	Total (line 5 plus line 25)	-8,792,844	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)	-8,792,844	29.00