This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/28/2019 1:23 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/28/2019 Time: 1:23 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RIVERVIEW HOSPITAL (15-0059) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-55,828	-44,157	0	-76,990	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-390	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	6,017	0		0	7.00
200.00	Total	0	-50,201	-44,157	0	-76,990	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 1:23 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 395 WESTFIELD ROAD	PO Box:			1.00
2.00	City: NOBLESVILLE	State: IN	Zip Code: 46060-	County: HAMILTON	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	RIVERVIEW HOSPITAL	150059	26900	1	07/07/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	RIVERVIEW HOSPITAL REHAB	15T059	26900	5	01/01/1994	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	RIVERVIEW HOSPITAL SNF	155669	26900		10/26/1999	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	9		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	320	1,093	0	0	1,024	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2019 1:23 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	133	0	0	87		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 1:23 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2019 1:23 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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.	Y			75.00

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		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N		0	76.00

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	977,147	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 1:23 pm

		1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

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

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2016	09/30/2016	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 1:23 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/28/2019 1:23 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/27/2019	Y	03/27/2019	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 1:23 pm

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

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL	ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7959	MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 1:23 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/28/2019 1:23 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	94	33,125	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		94	33,125	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	15	5,475	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		109	38,600	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	24	8,760		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	25	9,125		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		158				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: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2019 1:23 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,102	310	13,377			1.00
2.00	HMO and other (see instructions)	2,858	2,016				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	681	220				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,102	310	13,377			7.00
8.00	INTENSIVE CARE UNIT	1,165	0	2,792			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	6,267	310	16,169	0.00	1,047.43	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	3,471	0	5,314	0.00	23.54	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,105	0	4,574	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			52			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	1,070.97	27.00
28.00	Observation Bed Days		0	1,658			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	111	237			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: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2019 1:23 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,572	62	4,084	1.00
2.00	HMO and other (see instructions)			634	476		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				20		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	1,572	62	4,084	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	326	0	476	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II | Date/Time Prepared: 5/28/2019 1:23 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	78,140,998	1,915,334	80,056,332	2,227,182.00	35.95	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		30,014,824	195,275	30,210,099	616,841.00	48.98	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		264,632	0	264,632	7,248.00	36.51	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		635,178	0	635,178	2,960.00	214.59	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		9,545,514	0	9,545,514			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		4,518,438	0	4,518,438			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II | Date/Time Prepared: 5/28/2019 1:23 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	687,110	177,306	864,416	21,581.00	40.05	26.00
27.00	Administrative & General	5.00	8,305,878	-258,271	8,047,607	280,370.00	28.70	27.00
28.00	Administrative & General under contract (see inst.)		945,944	0	945,944	6,570.00	143.98	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,913,458	0	1,913,458	73,682.00	25.97	30.00
31.00	Laundry & Linen Service	8.00	49,115	0	49,115	2,814.00	17.45	31.00
32.00	Housekeeping	9.00	957,216	0	957,216	67,585.00	14.16	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,143,634	-830,383	313,251	20,559.00	15.24	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	745,037	745,037	42,953.00	17.35	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	469,438	0	469,438	9,488.00	49.48	38.00
39.00	Central Services and Supply	14.00	538,863	94,746	633,609	33,983.00	18.64	39.00
40.00	Pharmacy	15.00	2,754,672	-109,929	2,644,743	71,688.00	36.89	40.00
41.00	Medical Records & Medical Records Library	16.00	813,617	0	813,617	32,056.00	25.38	41.00
42.00	Social Service	17.00	605,705	0	605,705	15,599.00	38.83	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 5/28/2019 1:23 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		79,086,942	1,915,334	81,002,276	2,233,752.00	36.26	1.00
2.00	Excluded area salaries (see instructions)		30,014,824	195,275	30,210,099	616,841.00	48.98	2.00
3.00	Subtotal salaries (line 1 minus line 2)		49,072,118	1,720,059	50,792,177	1,616,911.00	31.41	3.00
4.00	Subtotal other wages & related costs (see inst.)		899,810	0	899,810	10,208.00	88.15	4.00
5.00	Subtotal wage-related costs (see inst.)		9,545,514	0	9,545,514	0.00	18.79	5.00
6.00	Total (sum of lines 3 thru 5)		59,517,442	1,720,059	61,237,501	1,627,119.00	37.64	6.00
7.00	Total overhead cost (see instructions)		19,184,650	-181,494	19,003,156	678,928.00	27.99	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 5/28/2019 1:23 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,187,948	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	7,158,640	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	258,634	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	33,536	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	257,070	14.00
15.00	'Workers' Compensation Insurance	118,461	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	4,986,474	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	4,116	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	59,073	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	14,063,952	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: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V | Date/Time Prepared: 5/28/2019 1:23 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	264,632	14,063,952	1.00
2.00	Hospital	264,632	14,063,952	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-7 | Date/Time Prepared: 5/28/2019 1:23 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	11	0	11	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	931	0	931	12.00
13.00		RUB	1,213	0	1,213	13.00
14.00		RUA	605	0	605	14.00
15.00		RVC	91	0	91	15.00
16.00		RVB	87	0	87	16.00
17.00		RVA	52	0	52	17.00
18.00		RHC	3	0	3	18.00
19.00		RHB	39	0	39	19.00
20.00		RHA	9	0	9	20.00
21.00		RMC	8	0	8	21.00
22.00		RMB	1	0	1	22.00
23.00		RMA	0	0	0	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	5	0	5	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	3	0	3	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	7	0	7	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	12	0	12	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	12	0	12	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	4	0	4	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet S-7 Date/Time Prepared: 5/28/2019 1:23 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	11	0	11	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	1	0	1	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,105	0	3,105	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	26900	26900	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2,643,269			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/28/2019 1:23 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.298578	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,629,617	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	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	37,950,993	6.00
7.00	Medicaid cost (line 1 times line 6)	11,331,332	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)	3,701,715	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,701,715	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)	6,505,621	1,314,498	7,820,119	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,942,435	1,314,498	3,256,933	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,942,435	1,314,498	3,256,933	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)	12,305,083	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	68,361	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	105,170	27.01
28.00	Non-Medicare bad debt expense (see instructions)	12,199,913	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,679,435	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,936,368	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,638,083	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		17,277,160	17,277,160	-213,606	17,063,554	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	687,110	5,858,041	6,545,151	177,306	6,722,457	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,305,878	26,346,952	34,652,830	-1,257,389	33,395,441	5.00
7.00	00700	OPERATION OF PLANT	1,913,458	4,731,828	6,645,286	-290	6,644,996	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	49,115	383,491	432,606	0	432,606	8.00
9.00	00900	HOUSEKEEPING	957,216	716,050	1,673,266	0	1,673,266	9.00
10.00	01000	DIETARY	1,143,634	1,957,705	3,101,339	-2,256,444	844,895	10.00
11.00	01100	CAFETERIA	0	0	0	2,020,413	2,020,413	11.00
13.00	01300	NURSING ADMINISTRATION	469,438	112,114	581,552	-1,198	580,354	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	538,863	888,016	1,426,879	15,111,852	16,538,731	14.00
15.00	01500	PHARMACY	2,754,672	19,903,177	22,657,849	-162,767	22,495,082	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	813,617	697,325	1,510,942	0	1,510,942	16.00
17.00	01700	SOCIAL SERVICE	605,705	181,885	787,590	0	787,590	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	119,246	119,246	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,475,258	1,263,361	8,738,619	-451,531	8,287,088	30.00
31.00	03100	INTENSIVE CARE UNIT	2,342,821	501,054	2,843,875	-273,415	2,570,460	31.00
41.00	04100	SUBPROVIDER - IRF	1,316,469	1,153,670	2,470,139	-89,241	2,380,898	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,110,076	2,110,076	-53,087	2,056,989	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,796,739	17,381,199	20,177,938	-11,847,556	8,330,382	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,681,285	815,037	2,496,322	2,122	2,498,444	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	413,677	596,691	1,010,368	52,755	1,063,123	55.00
57.00	05700	CT SCAN	266,475	193,541	460,016	-99,757	360,259	57.00
57.01	03630	ULTRA SOUND	194,675	17,724	212,399	-1,278	211,121	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	252,433	31,985	284,418	-5,603	278,815	58.00
59.00	05900	CARDIAC CATHETERIZATION	742,891	1,855,307	2,598,198	-993,971	1,604,227	59.00
60.00	06000	LABORATORY	2,823,247	3,741,346	6,564,593	-38,036	6,526,557	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	554,029	554,029	0	554,029	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,145,369	275,363	1,420,732	285,015	1,705,747	65.00
66.00	06600	PHYSICAL THERAPY	4,570,200	2,774,326	7,344,526	-7,390	7,337,136	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	698,668	160,090	858,758	144,054	1,002,812	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	908,585	908,585	0	908,585	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	326,104	326,104	-1,422	324,682	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	763,829	1,102,559	1,866,388	-144,272	1,722,116	76.01
76.02	03070	WOMEN'S CENTER	394,551	151,759	546,310	-82,205	464,105	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	348,245	142,881	491,126	-48,978	442,148	90.00
90.01	09001	OUTPATIENT	588,537	664,371	1,252,908	-158,078	1,094,830	90.01
90.02	09002	NEUROPSYCHOLOGY	94,173	15,619	109,792	0	109,792	90.02
91.00	09100	EMERGENCY	2,294,395	3,084,011	5,378,406	-195,039	5,183,367	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	57,403	46,809	104,212	0	104,212	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,500,046	118,921,241	168,421,287	-469,790	167,951,497	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	175,072	160,668	335,740	0	335,740	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	24,851,849	11,274,436	36,126,285	235,279	36,361,564	192.00
192.01	19201	FOUNDATION	167,172	12,466	179,638	0	179,638	192.01
192.02	19202	CLINICS	1,258,316	257,754	1,516,070	-507	1,515,563	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	1,489	1,489	0	1,489	192.03
192.04	19207	WESTFIELD SCHOOLS	1,077,175	129,799	1,206,974	-258	1,206,716	192.04
192.05	19203	PRACTICE MANAGEMENT	483,936	296,022	779,958	0	779,958	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	-18,110	-18,110	0	-18,110	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	137,098	137,098	0	137,098	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	627,432	312,712	940,144	0	940,144	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	235,276	235,276	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	78,140,998	131,485,575	209,626,573	0	209,626,573	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-42,331	17,021,223		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-103,408	6,619,049		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-10,542,862	22,852,579		5.00
7.00	00700	OPERATION OF PLANT	-1,997	6,642,999		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	432,606		8.00
9.00	00900	HOUSEKEEPING	0	1,673,266		9.00
10.00	01000	DIETARY	0	844,895		10.00
11.00	01100	CAFETERIA	-758,966	1,261,447		11.00
13.00	01300	NURSING ADMINISTRATION	0	580,354		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-3,364	16,535,367		14.00
15.00	01500	PHARMACY	-5,524,682	16,970,400		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,703	1,509,239		16.00
17.00	01700	SOCIAL SERVICE	0	787,590		17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	119,246		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,000	8,286,088		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,570,460		31.00
41.00	04100	SUBPROVIDER - IRF	0	2,380,898		41.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,056,989		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-3,674,424	4,655,958		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,650	2,495,794		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,063,123		55.00
57.00	05700	CT SCAN	0	360,259		57.00
57.01	03630	ULTRA SOUND	0	211,121		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	278,815		58.00
59.00	05900	CARDIAC CATHETERIZATION	-735,000	869,227		59.00
60.00	06000	LABORATORY	-108,611	6,417,946		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	554,029		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-310,000	1,395,747		65.00
66.00	06600	PHYSICAL THERAPY	0	7,337,136		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	-67,586	935,226		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	908,585		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	324,682		74.00
76.00	03020	OTHER ANCILLARY	0	0		76.00
76.01	03140	CARDIAC REHAB	0	1,722,116		76.01
76.02	03070	WOMEN'S CENTER	0	464,105		76.02
76.03	03330	ENDOSCOPY	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-4,908	437,240		90.00
90.01	09001	OUTPATIENT	-22,063	1,072,767		90.01
90.02	09002	NEUROPSYCHOLOGY	0	109,792		90.02
91.00	09100	EMERGENCY	-1,100,000	4,083,367		91.00
91.01	09101	SHORT STAY	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-3,290	100,922		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-23,008,845	144,942,652		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	335,740		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	36,361,564		192.00
192.01	19201	FOUNDATION	0	179,638		192.01
192.02	19202	CLINICS	0	1,515,563		192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	1,489		192.03
192.04	19207	WESTFIELD SCHOOLS	0	1,206,716		192.04
192.05	19203	PRACTICE MANAGEMENT	0	779,958		192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	-18,110		192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	137,098		192.08
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	WORKMED	0	940,144		194.00
194.01	07951	MEALS ON WHEELS	0	235,276		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-23,008,845	186,617,728		200.00

RECLASSIFICATIONS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 1:23 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	745,037	1,275,376	1.00
	TOTALS		745,037	1,275,376	
	B - MOW				
1.00	MEALS ON WHEELS	194.01	85,346	149,930	1.00
	TOTALS		85,346	149,930	
	C - INSURANCE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	213,606	1.00
	TOTALS		0	213,606	
	D - MED SUPPLY				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	15,017,106	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
	TOTALS		0	15,017,106	
	E - RSMA				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	177,306	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	94,746	0	2.00
3.00	OPERATING ROOM	50.00	1,901,553	0	3.00
	TOTALS		2,173,605	0	
	F - PHYSICIAN PROFESSIONAL FEES				
1.00	OPERATING ROOM	50.00	0	18,000	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	14,100	2.00
3.00	RADIOLOGY-THERAPEUTIC	55.00	0	52,800	3.00
4.00	LABORATORY	60.00	0	61,454	4.00
5.00	RESPIRATORY THERAPY	65.00	0	350,000	5.00
6.00	ELECTROCARDIOLOGY	69.00	0	151,308	6.00
7.00	OUTPATIENT	90.01	0	40,000	7.00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	783,333	8.00
	TOTALS		0	1,470,995	
	H - PARAMED ED				
1.00	PARAMED ED PRGM PHARMACY	23.00	109,929	9,317	1.00
	TOTALS		109,929	9,317	
	I - COMMUNITY RELATIONS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	258,271	1.00
	TOTALS		0	258,271	
500.00	Grand Total: Increases		3,113,917	18,394,601	500.00

RECLASSIFICATIONS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 1:23 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	745,037	1,275,376	0		1.00
	TOTALS		745,037	1,275,376			
	B - MOW						
1.00	DIETARY	10.00	85,346	149,930	0		1.00
	TOTALS		85,346	149,930			
	C - INSURANCE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	213,606	12		1.00
	TOTALS		0	213,606			
	D - MED SUPPLY						
1.00	OPERATION OF PLANT	7.00	0	290	0		1.00
2.00	DIETARY	10.00	0	755	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	1,198	0		3.00
4.00	PHARMACY	15.00	0	43,521	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	451,531	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	273,415	0		6.00
7.00	SUBPROVIDER - IRF	41.00	0	89,241	0		7.00
8.00	SKILLED NURSING FACILITY	44.00	0	53,087	0		8.00
9.00	OPERATING ROOM	50.00	0	11,593,504	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,978	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	45	0		11.00
12.00	CT SCAN	57.00	0	99,757	0		12.00
13.00	ULTRA SOUND	57.01	0	1,278	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	5,603	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	993,971	0		15.00
16.00	LABORATORY	60.00	0	99,490	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	64,985	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	7,390	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	7,254	0		19.00
20.00	RENAL DIALYSIS	74.00	0	1,422	0		20.00
21.00	CARDIAC REHAB	76.01	0	144,272	0		21.00
22.00	WOMEN'S CENTER	76.02	0	82,205	0		22.00
23.00	CLINIC	90.00	0	48,978	0		23.00
24.00	OUTPATIENT	90.01	0	198,078	0		24.00
25.00	EMERGENCY	91.00	0	195,039	0		25.00
26.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	548,054	0		26.00
27.00	CLINICS	192.02	0	507	0		27.00
28.00	WESTFIELD SCHOOLS	192.04	0	258	0		28.00
	TOTALS		0	15,017,106			
	E - RSMA						
1.00	OPERATING ROOM	50.00	0	2,173,605	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	2,173,605			
	F - PHYSICIAN PROFESSIONAL FEES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,470,995	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		0	1,470,995			
	H - PARAMED ED						
1.00	PHARMACY	15.00	109,929	9,317	0		1.00
	TOTALS		109,929	9,317			
	I - COMMUNITY RELATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	258,271	0	0		1.00
	TOTALS		258,271	0			
500.00	Grand Total: Decreases		1,198,583	20,309,935			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/28/2019 1:23 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	15,961,384	0	0	0	0	1.00
2.00	Land Improvements	2,892,112	96,033	0	96,033	8,983	2.00
3.00	Buildings and Fixtures	102,501,108	32,724,385	0	32,724,385	379,853	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	41,000,763	1,847,338	0	1,847,338	231,919	5.00
6.00	Movable Equipment	132,569,292	10,806,931	0	10,806,931	2,610,743	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	294,924,659	45,474,687	0	45,474,687	3,231,498	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	294,924,659	45,474,687	0	45,474,687	3,231,498	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	15,961,384	0	1.00
2.00	Land Improvements	2,979,162	0	2.00
3.00	Buildings and Fixtures	134,845,640	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	42,616,182	0	5.00
6.00	Movable Equipment	140,765,480	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	337,167,848	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	337,167,848	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/28/2019 1:23 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	15,533,459	0	1,389,105	354,596	0	1.00
3.00	Total (sum of lines 1-2)	15,533,459	0	1,389,105	354,596	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	17,277,160		1.00
3.00	Total (sum of lines 1-2)	0	17,277,160		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/28/2019 1:23 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	134,845,640	0	134,845,640	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	134,845,640	0	134,845,640	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	15,533,459	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	15,533,459	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,346,774	140,990	0	0	17,021,223	1.00
3.00	Total (sum of lines 1-2)	1,346,774	140,990	0	0	17,021,223	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/28/2019 1:23 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,964,136			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	-416,670			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-536,030	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
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: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/28/2019 1:23 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	HAF EXPENSE	A	-7,326,990	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	PHYSICIAN RECRUITMENT OFFSET	A	-3,100	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER REV MEDICAL REPORT	B	-1,703	MEDICAL RECORDS & LIBRARY	16.00	0	33.02
33.03	OTHER REVENUES ->PURCHASE DISCOUNTS	B	-20,625	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	NON-OP EXPENSE INVESTMENT FEES	B	208,449	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	RADIOLOGY- OTHER REVENUE-CDS FOR LEG	B	-2,650	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	AMBULANCE ->OTHER REVENUE	B	-3,290	AMBULANCE SERVICES	95.00	0	33.06
33.07	LABORATORY -> OTHER REVENUE	B	-108,611	LABORATORY	60.00	0	33.07
33.08	MATERNITY CENTER ->OTHER REVENUE	B	-1,000	ADULTS & PEDIATRICS	30.00	0	33.08
33.09	ENGINEERING- ENERGY REBATES	B	-1,997	OPERATION OF PLANT	7.00	0	33.09
33.10	WOUND CARE-OTHER REVENUE	B	-19,963	OUTPATIENT	90.01	0	33.10
33.11	INFORMATION SYSTEMS-OTHER REVENUE	B	-7,500	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	ADMINISTRATION-> LEAN TEAM	B	-496	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	WOUND CARE-OTHER REVENUE-WTA COURSE	B	-2,100	OUTPATIENT	90.01	0	33.13
33.14	EDUCATION -> OTHER REVENUE	B	-3,285	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	SHO/UNCLAIMED REFUNDS	B	1,013	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	OP PHARMACY REVENUE	B	-5,524,682	PHARMACY	15.00	0	33.16
33.17	DIETARY -> SALES PR DEDUCT	B	-222,936	CAFETERIA	11.00	0	33.17
33.18	WELLNESS SERVICES - EXTERNAL->-OTHER	B	-61,410	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	OTHER REV PREMIER PROGRAM	B	-3,364	CENTRAL SERVICES & SUPPLY	14.00	0	33.19
33.20	NON-OP REV -> MISCELLANEOUS INTEREST	B	-42,331	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.20
33.21	COMMUNITY RELATIONS	A	-2,222,044	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	COMMUNITY RELATIONS BENEFITS	A	-41,998	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.22
33.23	CRNA	A	-675,000	OPERATING ROOM	50.00	0	33.23
33.24	IHA LOBBYING EXPENSE	A	-4,396	ADMINISTRATIVE & GENERAL	5.00	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-23,008,845				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: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/28/2019 1:23 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	OPERATING ROOM	2,198,596	2,615,266	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,198,596	2,615,266	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:					
6.00	B	RMSA	100.00		0.00	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

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.

(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: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/28/2019 1:23 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-416,670	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-416,670			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/28/2019 1:23 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	100	100	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	695,960	695,960	0	0	0	2.00
3.00	50.00	OPERATING ROOM	2,951	2,951	0	0	0	3.00
4.00	50.00	OPERATING ROOM	388,696	388,696	0	0	0	4.00
5.00	50.00	OPERATING ROOM	-3,808	-3,808	0	0	0	5.00
6.00	50.00	OPERATING ROOM	102,860	102,860	0	0	0	6.00
7.00	90.00	CLINIC	4,847	4,847	0	0	0	7.00
8.00	90.00	CLINIC	61	61	0	0	0	8.00
9.00	50.00	OPERATING ROOM	-5,953	-5,953	0	0	0	9.00
10.00	50.00	OPERATING ROOM	493,943	493,943	0	0	0	10.00
11.00	50.00	OPERATING ROOM	5,609	5,609	0	0	0	11.00
12.00	91.00	EMERGENCY	1,100,000	1,100,000	0	0	0	12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	243,163	243,163	0	0	0	13.00
14.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	14.00
15.00	5.00	ADMINISTRATIVE & GENERAL	130,640	130,640	0	0	0	15.00
16.00	5.00	ADMINISTRATIVE & GENERAL	93,396	93,396	0	0	0	16.00
17.00	5.00	ADMINISTRATIVE & GENERAL	629	629	0	0	0	17.00
18.00	50.00	OPERATING ROOM	1,598,456	1,598,456	0	0	0	18.00
19.00	59.00	CARDIAC CATHETERIZATION	735,000	735,000	0	0	0	19.00
20.00	69.00	ELECTROCARDIOLOGY	67,586	67,586	0	0	0	20.00
21.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	21.00
22.00	65.00	RESPIRATORY THERAPY	310,000	310,000	0	0	0	22.00
200.00			5,964,136	5,964,136	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	50.00	OPERATING ROOM	0	0	0	0	0	9.00
10.00	50.00	OPERATING ROOM	0	0	0	0	0	10.00
11.00	50.00	OPERATING ROOM	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	13.00
14.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	14.00
15.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	15.00
16.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	16.00
17.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	17.00
18.00	50.00	OPERATING ROOM	0	0	0	0	0	18.00
19.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	19.00
20.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	20.00
21.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	21.00
22.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	22.00
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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	100		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	695,960		2.00
3.00	50.00	OPERATING ROOM	0	0	0	2,951		3.00
4.00	50.00	OPERATING ROOM	0	0	0	388,696		4.00
5.00	50.00	OPERATING ROOM	0	0	0	-3,808		5.00
6.00	50.00	OPERATING ROOM	0	0	0	102,860		6.00
7.00	90.00	CLINIC	0	0	0	4,847		7.00
8.00	90.00	CLINIC	0	0	0	61		8.00
9.00	50.00	OPERATING ROOM	0	0	0	-5,953		9.00
10.00	50.00	OPERATING ROOM	0	0	0	493,943		10.00
11.00	50.00	OPERATING ROOM	0	0	0	5,609		11.00
12.00	91.00	EMERGENCY	0	0	0	1,100,000		12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	243,163		13.00
14.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		14.00
15.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	130,640		15.00
16.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	93,396		16.00
17.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	629		17.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/28/2019 1:23 pm

	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		
18.00	50.00	OPERATING ROOM	0	0	0	1,598,456		18.00
19.00	59.00	CARDIAC CATHETERIZATION	0	0	0	735,000		19.00
20.00	69.00	ELECTROCARDIOLOGY	0	0	0	67,586		20.00
21.00	69.00	ELECTROCARDIOLOGY	0	0	0	0		21.00
22.00	65.00	RESPIRATORY THERAPY	0	0	0	310,000		22.00
200.00			0	0	0	5,964,136		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	17,021,223	17,021,223				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,619,049	93,406	6,712,455			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,852,579	1,364,318	1,035,508	25,252,405	25,252,405	5.00
7.00	00700	OPERATION OF PLANT	6,642,999	6,399,159	246,212	13,288,370	2,079,298	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	432,606	47,437	6,320	486,363	76,104	8.00
9.00	00900	HOUSEKEEPING	1,673,266	38,373	123,169	1,834,808	287,102	9.00
10.00	01000	DIETARY	844,895	350,184	40,307	1,235,386	193,307	10.00
11.00	01100	CAFETERIA	1,261,447	0	95,867	1,357,314	212,386	11.00
13.00	01300	NURSING ADMINISTRATION	580,354	12,193	60,404	652,951	102,171	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,535,367	139,050	81,529	16,755,946	2,621,887	14.00
15.00	01500	PHARMACY	16,970,400	221,371	340,310	17,532,081	2,743,332	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,509,239	100,644	104,691	1,714,574	268,288	16.00
17.00	01700	SOCIAL SERVICE	787,590	53,566	77,938	919,094	143,815	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	119,246	5,053	14,145	138,444	21,663	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,286,088	2,510,003	961,871	11,757,962	1,839,827	30.00
31.00	03100	INTENSIVE CARE UNIT	2,570,460	461,358	301,460	3,333,278	521,575	31.00
41.00	04100	SUBPROVIDER - IRF	2,380,898	321,493	169,395	2,871,786	449,363	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,056,989	301,736	0	2,358,725	369,081	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,655,958	1,215,944	324,862	6,196,764	969,639	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,495,794	231,608	216,338	2,943,740	460,622	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,063,123	231,511	53,229	1,347,863	210,907	55.00
57.00	05700	CT SCAN	360,259	49,523	34,288	444,070	69,486	57.00
57.01	03630	ULTRA SOUND	211,121	10,563	25,050	246,734	38,608	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	278,815	61,456	32,482	372,753	58,327	58.00
59.00	05900	CARDIAC CATHETERIZATION	869,227	93,863	95,591	1,058,681	165,657	59.00
60.00	06000	LABORATORY	6,417,946	419,529	363,278	7,200,753	1,126,738	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	554,029	63,640	0	617,669	96,650	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,395,747	68,563	147,379	1,611,689	252,189	65.00
66.00	06600	PHYSICAL THERAPY	7,337,136	97,319	588,066	8,022,521	1,255,324	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	935,226	349,206	89,900	1,374,332	215,049	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	908,585	0	0	908,585	142,171	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	324,682	30,288	0	354,970	55,544	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	1,722,116	51,577	98,285	1,871,978	292,918	76.01
76.02	03070	WOMEN'S CENTER	464,105	138,528	50,768	653,401	102,241	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	437,240	78,605	44,810	560,655	87,728	90.00
90.01	09001	OUTPATIENT	1,072,767	114,467	75,729	1,262,963	197,622	90.01
90.02	09002	NEUROPSYCHOLOGY	109,792	132,660	12,118	254,570	39,834	90.02
91.00	09100	EMERGENCY	4,083,367	510,034	295,229	4,888,630	764,948	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	100,922	11,215	7,386	119,523	18,702	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	144,942,652	16,379,443	6,213,914	143,802,331	18,550,103	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	335,740	199,364	22,527	557,631	87,255	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	36,361,564	442,416	0	36,803,980	5,758,832	192.00
192.01	19201	FOUNDATION	179,638	0	21,511	201,149	31,475	192.01
192.02	19202	CLINICS	1,515,563	0	161,913	1,677,476	262,483	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	1,489	0	0	1,489	233	192.03
192.04	19207	WESTFIELD SCHOOLS	1,206,716	0	138,604	1,345,320	210,509	192.04
192.05	19203	PRACTICE MANAGEMENT	779,958	0	62,270	842,228	131,788	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	-18,110	0	0	-18,110	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	137,098	0	0	137,098	21,452	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
194.00	07950	WORKMED	940,144	0	80,734	1,020,878	159,742	194.00
194.01	07951	MEALS ON WHEELS	235,276	0	10,982	246,258	38,533	194.01
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)	186,617,728	17,021,223	6,712,455	186,617,728	25,252,405	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	15,367,668					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,546	642,013				8.00
9.00	00900	HOUSEKEEPING	64,348	0	2,186,258			9.00
10.00	01000	DIETARY	587,222	0	8,924	2,024,839		10.00
11.00	01100	CAFETERIA	0	0	62,465	0	1,632,165	11.00
13.00	01300	NURSING ADMINISTRATION	20,447	0	0	0	13,216	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	233,172	4,826	2,231	0	47,335	14.00
15.00	01500	PHARMACY	371,217	0	55,772	0	99,855	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	168,770	0	11,154	0	44,651	16.00
17.00	01700	SOCIAL SERVICE	89,825	0	0	0	21,728	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	8,474	0	0	0	2,023	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,209,021	201,236	762,957	1,009,557	325,957	30.00
31.00	03100	INTENSIVE CARE UNIT	773,651	46,913	140,545	130,337	75,988	31.00
41.00	04100	SUBPROVIDER - IRF	539,112	50,160	140,545	450,805	68,212	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	505,981	46,562	136,083	434,140	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,039,014	62,311	238,704	0	148,167	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	388,384	37,596	35,694	0	77,765	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	388,220	5,194	22,309	0	13,492	55.00
57.00	05700	CT SCAN	83,045	0	0	0	11,812	57.00
57.01	03630	ULTRA SOUND	17,713	0	0	0	805	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	103,055	0	2,231	0	11,192	58.00
59.00	05900	CARDIAC CATHETERIZATION	157,398	16,565	0	0	25,064	59.00
60.00	06000	LABORATORY	703,508	0	78,081	0	148,809	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	106,718	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	114,973	0	6,693	0	46,488	65.00
66.00	06600	PHYSICAL THERAPY	163,193	5,413	0	0	205,315	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	585,582	5,510	44,618	0	33,341	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	50,789	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	86,490	474	60,234	0	31,465	76.01
76.02	03070	WOMEN'S CENTER	232,298	3,202	44,618	0	21,110	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	131,812	869	0	0	18,076	90.00
90.01	09001	OUTPATIENT	191,950	17,442	15,616	0	24,273	90.01
90.02	09002	NEUROPSYCHOLOGY	222,457	0	0	0	2,715	90.02
91.00	09100	EMERGENCY	855,275	86,659	189,624	0	84,699	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	18,807	0	0	0	2,886	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,291,467	590,932	2,059,098	2,024,839	1,606,439	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	334,314	0	2,231	0	12,538	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	741,887	50,642	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	6,194	192.01
192.02	19202	CLINICS	0	228	124,929	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	211	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	6,994	194.01
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)	15,367,668	642,013	2,186,258	2,024,839	1,632,165	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	788,785					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,665,397				14.00
15.00	01500	PHARMACY	0	0	20,802,257			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,207,437		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1,174,462	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	463,382	0	0	504,402	936,730	30.00
31.00	03100	INTENSIVE CARE UNIT	108,024	0	0	146,439	63,897	31.00
41.00	04100	SUBPROVIDER - IRF	96,971	0	0	0	102,408	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	71,427	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	862,366	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,271	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	59,660	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	43,389	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	390,505	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	59,660	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,665,397	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	20,802,257	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	120,408	0	0	108,474	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	788,785	19,665,397	20,802,257	2,191,166	1,174,462	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	FOUNDATION	0	0	0	0	0	192.01
192.02	19202	CLINICS	0	0	0	16,271	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/28/2019 1:23 pm

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
202.00	TOTAL (sum lines 118 through 201)	788,785	19,665,397	20,802,257	2,207,437	1,174,462	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
23.00	02300	PARAMED ED PRGM PHARMACY	170,604					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	22,011,031	0	22,011,031		30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,340,647	0	5,340,647		31.00
41.00	04100	SUBPROVIDER - IRF	0	4,769,362	0	4,769,362		41.00
43.00	04300	NURSERY	0	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	3,921,999	0	3,921,999		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,516,965	0	10,516,965		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,960,072	0	3,960,072		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,047,645	0	2,047,645		55.00
57.00	05700	CT SCAN	0	608,413	0	608,413		57.00
57.01	03630	ULTRA SOUND	0	303,860	0	303,860		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	547,558	0	547,558		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,423,365	0	1,423,365		59.00
60.00	06000	LABORATORY	0	9,301,278	0	9,301,278		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	821,037	0	821,037		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	2,032,032	0	2,032,032		65.00
66.00	06600	PHYSICAL THERAPY	0	10,042,271	0	10,042,271		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,318,092	0	2,318,092		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,665,397	0	19,665,397		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,050,756	0	1,050,756		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	170,604	20,972,861	0	20,972,861		73.00
74.00	07400	RENAL DIALYSIS	0	461,303	0	461,303		74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0		76.00
76.01	03140	CARDIAC REHAB	0	2,343,559	0	2,343,559		76.01
76.02	03070	WOMEN'S CENTER	0	1,056,870	0	1,056,870		76.02
76.03	03330	ENDOSCOPY	0	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	799,140	0	799,140		90.00
90.01	09001	OUTPATIENT	0	1,709,866	0	1,709,866		90.01
90.02	09002	NEUROPSYCHOLOGY	0	519,576	0	519,576		90.02
91.00	09100	EMERGENCY	0	7,098,717	0	7,098,717		91.00
91.01	09101	SHORT STAY	0	0	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	159,918	0	159,918		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	170,604	135,803,590	0	135,803,590		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	993,969	0	993,969		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	43,355,341	0	43,355,341		192.00
192.01	19201	FOUNDATION	0	238,818	0	238,818		192.01
192.02	19202	CLINICS	0	2,081,387	0	2,081,387		192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	1,722	0	1,722		192.03
192.04	19207	WESTFIELD SCHOOLS	0	1,555,829	0	1,555,829		192.04
192.05	19203	PRACTICE MANAGEMENT	0	974,227	0	974,227		192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	-18,110	0	-18,110		192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	158,550	0	158,550		192.08
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	WORKMED	0	1,180,620	0	1,180,620		194.00
194.01	07951	MEALS ON WHEELS	0	291,785	0	291,785		194.01

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/28/2019 1:23 pm

	Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.00	24.00	25.00	26.00		
200.00	Cross Foot Adjustments	0	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	170,604	186,617,728	0	186,617,728		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	93,406	93,406	93,406		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,364,318	1,364,318	14,388	1,378,706	5.00
7.00	00700	OPERATION OF PLANT	0	6,399,159	6,399,159	3,427	113,523	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,437	47,437	88	4,155	8.00
9.00	00900	HOUSEKEEPING	0	38,373	38,373	1,714	15,675	9.00
10.00	01000	DIETARY	0	350,184	350,184	561	10,554	10.00
11.00	01100	CAFETERIA	0	0	0	1,334	11,596	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,193	12,193	841	5,578	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	139,050	139,050	1,135	143,146	14.00
15.00	01500	PHARMACY	0	221,371	221,371	4,737	149,777	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	100,644	100,644	1,457	14,648	16.00
17.00	01700	SOCIAL SERVICE	0	53,566	53,566	1,085	7,852	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	5,053	5,053	197	1,183	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,510,003	2,510,003	13,388	100,448	30.00
31.00	03100	INTENSIVE CARE UNIT	0	461,358	461,358	4,196	28,476	31.00
41.00	04100	SUBPROVIDER - IRF	0	321,493	321,493	2,358	24,534	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	301,736	301,736	0	20,151	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,215,944	1,215,944	4,522	52,939	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	231,608	231,608	3,011	25,148	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	231,511	231,511	741	11,515	55.00
57.00	05700	CT SCAN	0	49,523	49,523	477	3,794	57.00
57.01	03630	ULTRA SOUND	0	10,563	10,563	349	2,108	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	61,456	61,456	452	3,184	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	93,863	93,863	1,331	9,044	59.00
60.00	06000	LABORATORY	0	419,529	419,529	5,056	61,516	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	63,640	63,640	0	5,277	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	68,563	68,563	2,051	13,769	65.00
66.00	06600	PHYSICAL THERAPY	0	97,319	97,319	8,185	68,536	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	349,206	349,206	1,251	11,741	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	7,762	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	30,288	30,288	0	3,033	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	51,577	51,577	1,368	15,992	76.01
76.02	03070	WOMEN'S CENTER	0	138,528	138,528	707	5,582	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	78,605	78,605	624	4,790	90.00
90.01	09001	OUTPATIENT	0	114,467	114,467	1,054	10,789	90.01
90.02	09002	NEUROPSYCHOLOGY	0	132,660	132,660	169	2,175	90.02
91.00	09100	EMERGENCY	0	510,034	510,034	4,109	41,764	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	11,215	11,215	103	1,021	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	16,379,443	16,379,443	86,466	1,012,775	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	199,364	199,364	314	4,764	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	442,416	442,416	0	314,421	192.00
192.01	19201	FOUNDATION	0	0	0	299	1,718	192.01
192.02	19202	CLINICS	0	0	0	2,254	14,331	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	13	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	1,929	11,493	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	867	7,195	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	1,171	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	1,124	8,721	194.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
194.01	07951	MEALS ON WHEELS	0	0	0	153	2,104	194.01
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	17,021,223	17,021,223	93,406	1,378,706	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	6,516,109					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,729	85,409				8.00
9.00	00900	HOUSEKEEPING	27,284	0	83,046			9.00
10.00	01000	DIETARY	248,991	0	339	610,629		10.00
11.00	01100	CAFETERIA	0	0	2,373	0	15,303	11.00
13.00	01300	NURSING ADMINISTRATION	8,670	0	0	0	124	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	98,868	642	85	0	444	14.00
15.00	01500	PHARMACY	157,401	0	2,119	0	936	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	71,561	0	424	0	419	16.00
17.00	01700	SOCIAL SERVICE	38,087	0	0	0	204	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	3,593	0	0	0	19	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,784,685	26,773	28,980	304,451	3,055	30.00
31.00	03100	INTENSIVE CARE UNIT	328,039	6,241	5,339	39,306	712	31.00
41.00	04100	SUBPROVIDER - IRF	228,591	6,673	5,339	135,949	640	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	214,543	6,194	5,169	130,923	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	864,571	8,289	9,067	0	1,389	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	164,680	5,001	1,356	0	729	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	164,611	691	847	0	126	55.00
57.00	05700	CT SCAN	35,212	0	0	0	111	57.00
57.01	03630	ULTRA SOUND	7,511	0	0	0	8	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	43,697	0	85	0	105	58.00
59.00	05900	CARDIAC CATHETERIZATION	66,739	2,204	0	0	235	59.00
60.00	06000	LABORATORY	298,297	0	2,966	0	1,395	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	45,250	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	48,750	0	254	0	436	65.00
66.00	06600	PHYSICAL THERAPY	69,196	720	0	0	1,925	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	248,295	733	1,695	0	313	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	21,535	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	36,673	63	2,288	0	295	76.01
76.02	03070	WOMEN'S CENTER	98,497	426	1,695	0	198	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	55,890	116	0	0	169	90.00
90.01	09001	OUTPATIENT	81,390	2,320	593	0	228	90.01
90.02	09002	NEUROPSYCHOLOGY	94,325	0	0	0	25	90.02
91.00	09100	EMERGENCY	362,649	11,528	7,203	0	794	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,974	0	0	0	27	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,059,784	78,614	78,216	610,629	15,061	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	141,754	0	85	0	118	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	314,571	6,737	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	58	192.01
192.02	19202	CLINICS	0	30	4,745	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	28	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	66	194.01
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)	6,516,109	85,409	83,046	610,629	15,303	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	27,406					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	383,370				14.00
15.00	01500	PHARMACY	0	0	536,341			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	189,153		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	100,794	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,100	0	0	43,222	80,391	30.00
31.00	03100	INTENSIVE CARE UNIT	3,753	0	0	12,548	5,484	31.00
41.00	04100	SUBPROVIDER - IRF	3,369	0	0	0	8,789	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	6,130	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	73,896	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,394	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	5,112	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	3,718	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	33,462	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	5,112	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	383,370	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	536,341	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	4,184	0	0	9,295	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,406	383,370	536,341	187,759	100,794	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	FOUNDATION	0	0	0	0	0	192.01
192.02	19202	CLINICS	0	0	0	1,394	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 1:23 pm

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
202.00	TOTAL (sum lines 118 through 201)	27,406	383,370	536,341	189,153	100,794	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
23.00	02300	PARAMED ED PRGM PHARMACY	10,045					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,911,496	0	4,911,496		30.00
31.00	03100	INTENSIVE CARE UNIT		895,452	0	895,452		31.00
41.00	04100	SUBPROVIDER - IRF		737,735	0	737,735		41.00
43.00	04300	NURSERY		0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY		684,846	0	684,846		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		2,230,617	0	2,230,617		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		432,927	0	432,927		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		415,154	0	415,154		55.00
57.00	05700	CT SCAN		89,117	0	89,117		57.00
57.01	03630	ULTRA SOUND		20,539	0	20,539		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		108,979	0	108,979		58.00
59.00	05900	CARDIAC CATHETERIZATION		173,416	0	173,416		59.00
60.00	06000	LABORATORY		792,477	0	792,477		60.00
60.01	06001	BLOOD LABORATORY		0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		114,167	0	114,167		63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY		133,823	0	133,823		65.00
66.00	06600	PHYSICAL THERAPY		279,343	0	279,343		66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY		618,346	0	618,346		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		383,370	0	383,370		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		7,762	0	7,762		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		536,341	0	536,341		73.00
74.00	07400	RENAL DIALYSIS		54,856	0	54,856		74.00
76.00	03020	OTHER ANCILLARY		0	0	0		76.00
76.01	03140	CARDIAC REHAB		108,256	0	108,256		76.01
76.02	03070	WOMEN'S CENTER		245,633	0	245,633		76.02
76.03	03330	ENDOSCOPY		0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		140,194	0	140,194		90.00
90.01	09001	OUTPATIENT		210,841	0	210,841		90.01
90.02	09002	NEUROPSYCHOLOGY		229,354	0	229,354		90.02
91.00	09100	EMERGENCY		951,560	0	951,560		91.00
91.01	09101	SHORT STAY		0	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		20,340	0	20,340		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	15,526,941	0	15,526,941		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		346,399	0	346,399		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		1,078,145	0	1,078,145		192.00
192.01	19201	FOUNDATION		2,075	0	2,075		192.01
192.02	19202	CLINICS		22,754	0	22,754		192.02
192.03	19206	HOME HEALTH PARTNERSHIP		13	0	13		192.03
192.04	19207	WESTFIELD SCHOOLS		13,422	0	13,422		192.04
192.05	19203	PRACTICE MANAGEMENT		8,090	0	8,090		192.05
192.06	19204	MOB - NOBLESVILLE SQUARE		0	0	0		192.06
192.08	19205	RIVERVIEW MEDICAL ARTS		1,171	0	1,171		192.08
193.00	19300	NONPAID WORKERS		0	0	0		193.00
194.00	07950	WORKMED		9,845	0	9,845		194.00
194.01	07951	MEALS ON WHEELS		2,323	0	2,323		194.01

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 1:23 pm

	Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.00	24.00	25.00	26.00		
200.00	Cross Foot Adjustments	10,045	10,045	0	10,045		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	10,045	17,021,223	0	17,021,223		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	522,083					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,865	52,166,462				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	41,847	8,047,607	-25,252,405	161,383,433		5.00
7.00	00700	OPERATION OF PLANT	196,278	1,913,458	0	13,288,370	281,093	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,455	49,115	0	486,363	1,455	8.00
9.00	00900	HOUSEKEEPING	1,177	957,216	0	1,834,808	1,177	9.00
10.00	01000	DIETARY	10,741	313,251	0	1,235,386	10,741	10.00
11.00	01100	CAFETERIA	0	745,037	0	1,357,314	0	11.00
13.00	01300	NURSING ADMINISTRATION	374	469,438	0	652,951	374	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,265	633,609	0	16,755,946	4,265	14.00
15.00	01500	PHARMACY	6,790	2,644,743	0	17,532,081	6,790	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,087	813,617	0	1,714,574	3,087	16.00
17.00	01700	SOCIAL SERVICE	1,643	605,705	0	919,094	1,643	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	155	109,929	0	138,444	155	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	76,988	7,475,258	0	11,757,962	76,988	30.00
31.00	03100	INTENSIVE CARE UNIT	14,151	2,342,821	0	3,333,278	14,151	31.00
41.00	04100	SUBPROVIDER - IRF	9,861	1,316,469	0	2,871,786	9,861	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	9,255	0	0	2,358,725	9,255	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,296	2,524,687	0	6,196,764	37,296	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,104	1,681,285	0	2,943,740	7,104	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,101	413,677	0	1,347,863	7,101	55.00
57.00	05700	CT SCAN	1,519	266,475	0	444,070	1,519	57.00
57.01	03630	ULTRA SOUND	324	194,675	0	246,734	324	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,885	252,433	0	372,753	1,885	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,879	742,891	0	1,058,681	2,879	59.00
60.00	06000	LABORATORY	12,868	2,823,247	0	7,200,753	12,868	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,952	0	0	617,669	1,952	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,103	1,145,369	0	1,611,689	2,103	65.00
66.00	06600	PHYSICAL THERAPY	2,985	4,570,200	0	8,022,521	2,985	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	10,711	698,668	0	1,374,332	10,711	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	908,585	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	929	0	0	354,970	929	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	1,582	763,829	0	1,871,978	1,582	76.01
76.02	03070	WOMEN'S CENTER	4,249	394,551	0	653,401	4,249	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,411	348,245	0	560,655	2,411	90.00
90.01	09001	OUTPATIENT	3,511	588,537	0	1,262,963	3,511	90.01
90.02	09002	NEUROPSYCHOLOGY	4,069	94,173	0	254,570	4,069	90.02
91.00	09100	EMERGENCY	15,644	2,294,395	0	4,888,630	15,644	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	344	57,403	0	119,523	344	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	502,398	48,292,013	-25,252,405	118,549,926	261,408	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,115	175,072	0	557,631	6,115	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,570	0	0	36,803,980	13,570	192.00
192.01	19201	FOUNDATION	0	167,172	0	201,149	0	192.01
192.02	19202	CLINICS	0	1,258,316	0	1,677,476	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	1,489	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	1,077,175	0	1,345,320	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	483,936	0	842,228	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	18,110	0	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	137,098	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
194.00	07950	WORKMED	0	627,432	0	1,020,878	0	194.00
194.01	07951	MEALS ON WHEELS	0	85,346	0	246,258	0	194.01
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)	17,021,223	6,712,455		25,252,405	15,367,668	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.602523	0.128674		0.156475	54.671116	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		93,406		1,378,706	6,516,109	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001791		0.008543	23.181328	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: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	73,174					8.00
9.00	00900	HOUSEKEEPING	0	980				9.00
10.00	01000	DIETARY	0	4	83,472			10.00
11.00	01100	CAFETERIA	0	28	0	1,171,764		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	9,488	398,343	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	550	1	0	33,983	0	14.00
15.00	01500	PHARMACY	0	25	0	71,688	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5	0	32,056	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	15,599	0	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	1,452	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,936	342	41,618	234,012	234,012	30.00
31.00	03100	INTENSIVE CARE UNIT	5,347	63	5,373	54,553	54,553	31.00
41.00	04100	SUBPROVIDER - IRF	5,717	63	18,584	48,971	48,971	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	5,307	61	17,897	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,102	107	0	106,372	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,285	16	0	55,829	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	592	10	0	9,686	0	55.00
57.00	05700	CT SCAN	0	0	0	8,480	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	578	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1	0	8,035	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,888	0	0	17,994	0	59.00
60.00	06000	LABORATORY	0	35	0	106,833	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3	0	33,375	0	65.00
66.00	06600	PHYSICAL THERAPY	617	0	0	147,400	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	628	20	0	23,936	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	54	27	0	22,589	0	76.01
76.02	03070	WOMEN'S CENTER	365	20	0	15,155	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	99	0	0	12,977	0	90.00
90.01	09001	OUTPATIENT	1,988	7	0	17,426	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	1,949	0	90.02
91.00	09100	EMERGENCY	9,877	85	0	60,807	60,807	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	2,072	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,352	923	83,472	1,153,295	398,343	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1	0	9,001	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,772	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	4,447	0	192.01
192.02	19202	CLINICS	26	56	0	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	24	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	5,021	0	194.01

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
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)	642,013	2,186,258	2,024,839	1,632,165	788,785	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.773786	2,230.875510	24.257703	1.392913	1.980165	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	85,409	83,046	610,629	15,303	27,406	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.167204	84.740816	7.315375	0.013060	0.068800	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: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	PARAMED ED PRGM PHARMACY (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	100					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	407			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	5,459		17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	0	100	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	93	4,354	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	27	297	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	476	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	332	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	159	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	11	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	8	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	72	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	11	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	100	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	20	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	404	5,459	100	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	FOUNDATION	0	0	0	0	0	192.01
192.02	19202	CLINICS	0	0	3	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 1:23 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	PARAMED ED PRGM PHARMACY (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	23.00	
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)	19,665,397	20,802,257	2,207,437	1,174,462	170,604	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	196,653.970000	208,022.570000	5,423.678133	215.142334	1,706.040000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	383,370	536,341	189,153	100,794	10,045	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3,833.700000	5,363.410000	464.749386	18.463821	100.450000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 1:23 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,011,031		22,011,031	0	22,011,031	30.00
31.00	03100	INTENSIVE CARE UNIT	5,340,647		5,340,647	0	5,340,647	31.00
41.00	04100	SUBPROVIDER - IRF	4,769,362		4,769,362	0	4,769,362	41.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	3,921,999		3,921,999	0	3,921,999	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,516,965		10,516,965	0	10,516,965	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,960,072		3,960,072	0	3,960,072	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,047,645		2,047,645	0	2,047,645	55.00
57.00	05700	CT SCAN	608,413		608,413	0	608,413	57.00
57.01	03630	ULTRA SOUND	303,860		303,860	0	303,860	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	547,558		547,558	0	547,558	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,423,365		1,423,365	0	1,423,365	59.00
60.00	06000	LABORATORY	9,301,278		9,301,278	0	9,301,278	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	821,037		821,037	0	821,037	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,032,032	0	2,032,032	0	2,032,032	65.00
66.00	06600	PHYSICAL THERAPY	10,042,271	0	10,042,271	0	10,042,271	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	2,318,092		2,318,092	0	2,318,092	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,665,397		19,665,397	0	19,665,397	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,050,756		1,050,756	0	1,050,756	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,972,861		20,972,861	0	20,972,861	73.00
74.00	07400	RENAL DIALYSIS	461,303		461,303	0	461,303	74.00
76.00	03020	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03140	CARDIAC REHAB	2,343,559		2,343,559	0	2,343,559	76.01
76.02	03070	WOMEN'S CENTER	1,056,870		1,056,870	0	1,056,870	76.02
76.03	03330	ENDOSCOPY	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	799,140		799,140	0	799,140	90.00
90.01	09001	OUTPATIENT	1,709,866		1,709,866	0	1,709,866	90.01
90.02	09002	NEUROPSYCHOLOGY	519,576		519,576	0	519,576	90.02
91.00	09100	EMERGENCY	7,098,717		7,098,717	0	7,098,717	91.00
91.01	09101	SHORT STAY	0		0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,427,295		2,427,295		2,427,295	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	159,918		159,918	0	159,918	95.00
200.00		Subtotal (see instructions)	138,230,885	0	138,230,885	0	138,230,885	200.00
201.00		Less Observation Beds	2,427,295		2,427,295		2,427,295	201.00
202.00		Total (see instructions)	135,803,590	0	135,803,590	0	135,803,590	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/28/2019 1:23 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,145,877		29,145,877			30.00
31.00	03100	INTENSIVE CARE UNIT	7,748,707		7,748,707			31.00
41.00	04100	SUBPROVIDER - IRF	6,253,039		6,253,039			41.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	2,643,269		2,643,269			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,070,110	49,913,360	79,983,470	0.131489	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,878,402	10,540,847	12,419,249	0.318866	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	82,189	7,688,035	7,770,224	0.263525	0.000000	55.00
57.00	05700	CT SCAN	3,051,823	13,015,623	16,067,446	0.037866	0.000000	57.00
57.01	03630	ULTRA SOUND	1,119,101	4,031,302	5,150,403	0.058997	0.000000	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	624,182	4,198,072	4,822,254	0.113548	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,619,752	12,757,576	20,377,328	0.069850	0.000000	59.00
60.00	06000	LABORATORY	13,909,986	32,695,645	46,605,631	0.199574	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,074,548	589,924	1,664,472	0.493272	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,688,099	1,420,636	6,108,735	0.332644	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	12,675,311	16,158,098	28,833,409	0.348286	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,862,740	8,401,386	10,264,126	0.225844	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,898,950	18,395,204	37,294,154	0.527305	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,416,460	7,390,000	15,806,460	0.066476	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,003,490	37,988,252	52,991,742	0.395776	0.000000	73.00
74.00	07400	RENAL DIALYSIS	714,622	3,712	718,334	0.642185	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03140	CARDIAC REHAB	593,858	10,235,686	10,829,544	0.216404	0.000000	76.01
76.02	03070	WOMEN'S CENTER	7,999	6,753,275	6,761,274	0.156312	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,967	5,608,484	5,614,451	0.142336	0.000000	90.00
90.01	09001	OUTPATIENT	245,594	4,556,726	4,802,320	0.356050	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	612,641	612,641	0.848092	0.000000	90.02
91.00	09100	EMERGENCY	4,749,859	25,038,386	29,788,245	0.238306	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0.000000	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	593,886	3,163,528	3,757,414	0.646001	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	173,677,820	281,156,398	454,834,218			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	173,677,820	281,156,398	454,834,218			202.00

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.131489	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.318866	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.263525	55.00
57.00	05700	CT SCAN	0.037866	57.00
57.01	03630	ULTRA SOUND	0.058997	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.113548	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.069850	59.00
60.00	06000	LABORATORY	0.199574	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.493272	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.332644	65.00
66.00	06600	PHYSICAL THERAPY	0.348286	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.225844	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.527305	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.066476	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.395776	73.00
74.00	07400	RENAL DIALYSIS	0.642185	74.00
76.00	03020	OTHER ANCILLARY	0.000000	76.00
76.01	03140	CARDIAC REHAB	0.216404	76.01
76.02	03070	WOMEN'S CENTER	0.156312	76.02
76.03	03330	ENDOSCOPY	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.142336	90.00
90.01	09001	OUTPATIENT	0.356050	90.01
90.02	09002	NEUROPSYCHOLOGY	0.848092	90.02
91.00	09100	EMERGENCY	0.238306	91.00
91.01	09101	SHORT STAY	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.646001	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 1:23 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,011,031		22,011,031	0	22,011,031	30.00
31.00	03100	INTENSIVE CARE UNIT	5,340,647		5,340,647	0	5,340,647	31.00
41.00	04100	SUBPROVIDER - IRF	4,769,362		4,769,362	0	4,769,362	41.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	3,921,999		3,921,999	0	3,921,999	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,516,965		10,516,965	0	10,516,965	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,960,072		3,960,072	0	3,960,072	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,047,645		2,047,645	0	2,047,645	55.00
57.00	05700	CT SCAN	608,413		608,413	0	608,413	57.00
57.01	03630	ULTRA SOUND	303,860		303,860	0	303,860	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	547,558		547,558	0	547,558	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,423,365		1,423,365	0	1,423,365	59.00
60.00	06000	LABORATORY	9,301,278		9,301,278	0	9,301,278	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	821,037		821,037	0	821,037	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,032,032	0	2,032,032	0	2,032,032	65.00
66.00	06600	PHYSICAL THERAPY	10,042,271	0	10,042,271	0	10,042,271	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	2,318,092		2,318,092	0	2,318,092	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,665,397		19,665,397	0	19,665,397	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,050,756		1,050,756	0	1,050,756	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,972,861		20,972,861	0	20,972,861	73.00
74.00	07400	RENAL DIALYSIS	461,303		461,303	0	461,303	74.00
76.00	03020	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03140	CARDIAC REHAB	2,343,559		2,343,559	0	2,343,559	76.01
76.02	03070	WOMEN'S CENTER	1,056,870		1,056,870	0	1,056,870	76.02
76.03	03330	ENDOSCOPY	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	799,140		799,140	0	799,140	90.00
90.01	09001	OUTPATIENT	1,709,866		1,709,866	0	1,709,866	90.01
90.02	09002	NEUROPSYCHOLOGY	519,576		519,576	0	519,576	90.02
91.00	09100	EMERGENCY	7,098,717		7,098,717	0	7,098,717	91.00
91.01	09101	SHORT STAY	0		0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,427,295		2,427,295		2,427,295	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	159,918		159,918	0	159,918	95.00
200.00		Subtotal (see instructions)	138,230,885	0	138,230,885	0	138,230,885	200.00
201.00		Less Observation Beds	2,427,295		2,427,295		2,427,295	201.00
202.00		Total (see instructions)	135,803,590	0	135,803,590	0	135,803,590	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 1:23 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,145,877		29,145,877			30.00
31.00	03100	INTENSIVE CARE UNIT	7,748,707		7,748,707			31.00
41.00	04100	SUBPROVIDER - IRF	6,253,039		6,253,039			41.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	2,643,269		2,643,269			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,070,110	49,913,360	79,983,470	0.131489	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,878,402	10,540,847	12,419,249	0.318866	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	82,189	7,688,035	7,770,224	0.263525	0.000000	55.00
57.00	05700	CT SCAN	3,051,823	13,015,623	16,067,446	0.037866	0.000000	57.00
57.01	03630	ULTRA SOUND	1,119,101	4,031,302	5,150,403	0.058997	0.000000	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	624,182	4,198,072	4,822,254	0.113548	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,619,752	12,757,576	20,377,328	0.069850	0.000000	59.00
60.00	06000	LABORATORY	13,909,986	32,695,645	46,605,631	0.199574	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,074,548	589,924	1,664,472	0.493272	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,688,099	1,420,636	6,108,735	0.332644	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	12,675,311	16,158,098	28,833,409	0.348286	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,862,740	8,401,386	10,264,126	0.225844	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,898,950	18,395,204	37,294,154	0.527305	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,416,460	7,390,000	15,806,460	0.066476	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,003,490	37,988,252	52,991,742	0.395776	0.000000	73.00
74.00	07400	RENAL DIALYSIS	714,622	3,712	718,334	0.642185	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03140	CARDIAC REHAB	593,858	10,235,686	10,829,544	0.216404	0.000000	76.01
76.02	03070	WOMEN'S CENTER	7,999	6,753,275	6,761,274	0.156312	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,967	5,608,484	5,614,451	0.142336	0.000000	90.00
90.01	09001	OUTPATIENT	245,594	4,556,726	4,802,320	0.356050	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	612,641	612,641	0.848092	0.000000	90.02
91.00	09100	EMERGENCY	4,749,859	25,038,386	29,788,245	0.238306	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0.000000	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	593,886	3,163,528	3,757,414	0.646001	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	173,677,820	281,156,398	454,834,218			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	173,677,820	281,156,398	454,834,218			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 1:23 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
57.01	03630	ULTRA SOUND	0.000000		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	OTHER ANCILLARY	0.000000		76.00
76.01	03140	CARDIAC REHAB	0.000000		76.01
76.02	03070	WOMEN'S CENTER	0.000000		76.02
76.03	03330	ENDOSCOPY	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OUTPATIENT	0.000000		90.01
90.02	09002	NEUROPSYCHOLOGY	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
91.01	09101	SHORT STAY	0.000000		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,911,496	0	4,911,496	15,035	326.67	30.00
31.00	INTENSIVE CARE UNIT	895,452		895,452	2,792	320.72	31.00
41.00	SUBPROVIDER - IRF	737,735	0	737,735	5,314	138.83	41.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	684,846		684,846	4,574	149.73	44.00
200.00	Total (lines 30 through 199)	7,229,529		7,229,529	27,715		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	5,102	1,666,670	30.00
31.00	INTENSIVE CARE UNIT	1,165	373,639	31.00
41.00	SUBPROVIDER - IRF	3,471	481,879	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	3,105	464,912	44.00
200.00	Total (lines 30 through 199)	12,843	2,987,100	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,230,617	79,983,470	0.027888	12,503,822	348,707	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	432,927	12,419,249	0.034859	841,508	29,334	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	415,154	7,770,224	0.053429	20,874	1,115	55.00
57.00	05700	CT SCAN	89,117	16,067,446	0.005546	1,162,747	6,449	57.00
57.01	03630	ULTRA SOUND	20,539	5,150,403	0.003988	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	108,979	4,822,254	0.022599	205,947	4,654	58.00
59.00	05900	CARDIAC CATHETERIZATION	173,416	20,377,328	0.008510	2,036,810	17,333	59.00
60.00	06000	LABORATORY	792,477	46,605,631	0.017004	5,494,495	93,428	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	114,167	1,664,472	0.068591	301,393	20,673	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	133,823	6,108,735	0.021907	1,973,474	43,233	65.00
66.00	06600	PHYSICAL THERAPY	279,343	28,833,409	0.009688	1,519,776	14,724	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	618,346	10,264,126	0.060243	1,197,011	72,112	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	383,370	37,294,154	0.010280	6,727,097	69,155	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,762	15,806,460	0.000491	3,278,560	1,610	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	536,341	52,991,742	0.010121	5,355,634	54,204	73.00
74.00	07400	RENAL DIALYSIS	54,856	718,334	0.076366	289,163	22,082	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	108,256	10,829,544	0.009996	122,672	1,226	76.01
76.02	03070	WOMEN'S CENTER	245,633	6,761,274	0.036329	1,043	38	76.02
76.03	03330	ENDOSCOPY	0	0	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	140,194	5,614,451	0.024970	4,320	108	90.00
90.01	09001	OUTPATIENT	210,841	4,802,320	0.043904	84,997	3,732	90.01
90.02	09002	NEUROPSYCHOLOGY	229,354	612,641	0.374369	0	0	90.02
91.00	09100	EMERGENCY	951,560	29,788,245	0.031944	2,262,571	72,276	91.00
91.01	09101	SHORT STAY	0	0	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	541,622	3,757,414	0.144148	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	8,818,694	409,043,326		45,383,914	876,193	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/28/2019 1:23 pm

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	15,035	0.00	5,102	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,792	0.00	1,165	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	5,314	0.00	3,471	41.00
43.00	04300	NURSERY		0	0	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	4,574	0.00	3,105	44.00
200.00		Total (lines 30 through 199)		0	27,715		12,843	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	170,604	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
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	170,604	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	79,983,470	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,419,249	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	7,770,224	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	16,067,446	0.000000	57.00
57.01	03630	ULTRA SOUND	0	0	0	5,150,403	0.000000	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	4,822,254	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	20,377,328	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	46,605,631	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,664,472	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,108,735	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	28,833,409	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,264,126	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	37,294,154	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	15,806,460	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	170,604	170,604	52,991,742	0.003219	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	718,334	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03140	CARDIAC REHAB	0	0	0	10,829,544	0.000000	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	6,761,274	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,614,451	0.000000	90.00
90.01	09001	OUTPATIENT	0	0	0	4,802,320	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	612,641	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	29,788,245	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,757,414	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	170,604	170,604	409,043,326		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	12,503,822	0	10,660,125	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	841,508	0	1,904,122	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	20,874	0	3,052,147	0	55.00
57.00	05700	CT SCAN	0.000000	1,162,747	0	3,492,601	0	57.00
57.01	03630	ULTRA SOUND	0.000000	0	0	22,865	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	205,947	0	1,088,804	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,036,810	0	5,531,100	0	59.00
60.00	06000	LABORATORY	0.000000	5,494,495	0	3,482,978	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	301,393	0	132,836	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,973,474	0	619,445	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,519,776	0	93,895	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,197,011	0	3,357,392	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	6,727,097	0	4,779,292	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	3,278,560	0	2,019,023	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003219	5,355,634	17,240	16,308,023	52,496	73.00
74.00	07400	RENAL DIALYSIS	0.000000	289,163	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.000000	122,672	0	4,436,770	0	76.01
76.02	03070	WOMEN'S CENTER	0.000000	1,043	0	690,674	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	4,320	0	2,269,892	0	90.00
90.01	09001	OUTPATIENT	0.000000	84,997	0	1,591,169	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.000000	0	0	224,453	0	90.02
91.00	09100	EMERGENCY	0.000000	2,262,571	0	3,910,319	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	789,126	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		45,383,914	17,240	70,457,051	52,496	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.131489	10,660,125	0	0	1,401,689	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.318866	1,904,122	0	0	607,160	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.263525	3,052,147	0	0	804,317	55.00
57.00	05700	CT SCAN	0.037866	3,492,601	0	0	132,251	57.00
57.01	03630	ULTRA SOUND	0.058997	22,865	0	0	1,349	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.113548	1,088,804	0	0	123,632	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.069850	5,531,100	0	0	386,347	59.00
60.00	06000	LABORATORY	0.199574	3,482,978	0	0	695,112	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.493272	132,836	0	0	65,524	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.332644	619,445	0	0	206,055	65.00
66.00	06600	PHYSICAL THERAPY	0.348286	93,895	0	0	32,702	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.225844	3,357,392	0	0	758,247	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.527305	4,779,292	0	0	2,520,145	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.066476	2,019,023	0	0	134,217	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.395776	16,308,023	0	18,439	6,454,324	73.00
74.00	07400	RENAL DIALYSIS	0.642185	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.216404	4,436,770	0	0	960,135	76.01
76.02	03070	WOMEN'S CENTER	0.156312	690,674	0	0	107,961	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.142336	2,269,892	0	0	323,087	90.00
90.01	09001	OUTPATIENT	0.356050	1,591,169	0	0	566,536	90.01
90.02	09002	NEUROPSYCHOLOGY	0.848092	224,453	0	0	190,357	90.02
91.00	09100	EMERGENCY	0.238306	3,910,319	0	0	931,852	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.646001	789,126	0	0	509,776	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		70,457,051	0	18,439	17,912,775	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		70,457,051	0	18,439	17,912,775	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
57.01	03630	ULTRA SOUND	0	0		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,298		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	OTHER ANCILLARY	0	0		76.00
76.01	03140	CARDIAC REHAB	0	0		76.01
76.02	03070	WOMEN'S CENTER	0	0		76.02
76.03	03330	ENDOSCOPY	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT	0	0		90.01
90.02	09002	NEUROPSYCHOLOGY	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	SHORT STAY	0	0		91.01
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	7,298		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	7,298		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II | Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Subprovider - IRF | 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	2,230,617	79,983,470	0.027888	134,793	3,759	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	432,927	12,419,249	0.034859	49,014	1,709	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	415,154	7,770,224	0.053429	0	0	55.00
57.00	05700	CT SCAN	89,117	16,067,446	0.005546	56,963	316	57.00
57.01	03630	ULTRA SOUND	20,539	5,150,403	0.003988	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	108,979	4,822,254	0.022599	19,327	437	58.00
59.00	05900	CARDIAC CATHETERIZATION	173,416	20,377,328	0.008510	19,513	166	59.00
60.00	06000	LABORATORY	792,477	46,605,631	0.017004	728,606	12,389	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	114,167	1,664,472	0.068591	9,916	680	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	133,823	6,108,735	0.021907	312,976	6,856	65.00
66.00	06600	PHYSICAL THERAPY	279,343	28,833,409	0.009688	3,778,290	36,604	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	618,346	10,264,126	0.060243	38,332	2,309	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	383,370	37,294,154	0.010280	619,842	6,372	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,762	15,806,460	0.000491	7,802	4	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	536,341	52,991,742	0.010121	930,277	9,415	73.00
74.00	07400	RENAL DIALYSIS	54,856	718,334	0.076366	141,872	10,834	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	108,256	10,829,544	0.009996	4,890	49	76.01
76.02	03070	WOMEN'S CENTER	245,633	6,761,274	0.036329	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	140,194	5,614,451	0.024970	1,290	32	90.00
90.01	09001	OUTPATIENT	210,841	4,802,320	0.043904	34,500	1,515	90.01
90.02	09002	NEUROPSYCHOLOGY	229,354	612,641	0.374369	0	0	90.02
91.00	09100	EMERGENCY	951,560	29,788,245	0.031944	46,760	1,494	91.00
91.01	09101	SHORT STAY	0	0	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,757,414	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	8,277,072	409,043,326		6,934,963	94,940	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	170,604	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
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	170,604	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Subprovider - IRF | 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	79,983,470	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,419,249	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	7,770,224	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	16,067,446	0.000000	57.00
57.01	03630	ULTRA SOUND	0	0	0	5,150,403	0.000000	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	4,822,254	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	20,377,328	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	46,605,631	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,664,472	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,108,735	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	28,833,409	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,264,126	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	37,294,154	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	15,806,460	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	170,604	170,604	52,991,742	0.003219	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	718,334	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03140	CARDIAC REHAB	0	0	0	10,829,544	0.000000	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	6,761,274	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,614,451	0.000000	90.00
90.01	09001	OUTPATIENT	0	0	0	4,802,320	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	612,641	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	29,788,245	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,757,414	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	170,604	170,604	409,043,326		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Subprovider - IRF | 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	134,793	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	49,014	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	56,963	0	0	0	57.00
57.01	03630	ULTRA SOUND	0.000000	0	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	19,327	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	19,513	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	728,606	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	9,916	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	312,976	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,778,290	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	38,332	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	619,842	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	7,802	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003219	930,277	2,995	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	141,872	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.000000	4,890	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0.000000	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	1,290	0	0	0	90.00
90.01	09001	OUTPATIENT	0.000000	34,500	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	46,760	0	0	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
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)		6,934,963	2,995	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Component CCN: 15-5669 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	170,604	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
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	170,604	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Component CCN: 15-5669 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Skilled Nursing Facility | 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	79,983,470	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,419,249	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	7,770,224	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	16,067,446	0.000000	57.00
57.01	03630	ULTRA SOUND	0	0	0	5,150,403	0.000000	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	4,822,254	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	20,377,328	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	46,605,631	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,664,472	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,108,735	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	28,833,409	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,264,126	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	37,294,154	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	15,806,460	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	170,604	170,604	52,991,742	0.003219	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	718,334	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03140	CARDIAC REHAB	0	0	0	10,829,544	0.000000	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	6,761,274	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,614,451	0.000000	90.00
90.01	09001	OUTPATIENT	0	0	0	4,802,320	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	612,641	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	29,788,245	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,757,414	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	170,604	170,604	409,043,326		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Component CCN: 15-5669 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	30,890	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0.000000	0	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	13,951	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,047,422	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	229,106	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,408,450	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	375	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	288,438	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003219	1,907,506	6,140	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.000000	1,815	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0.000000	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0.000000	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
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)		4,927,953	6,140	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,035	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,035	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)	13,377	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,102	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	22,011,031	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	22,011,031	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)	22,011,031	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)	1,463.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,469,277	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)	7,469,277	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,340,647	2,792	1,912.84	1,165	2,228,459	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)	11,496,252	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	21,193,988	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)	2,040,309	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	893,433	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,933,742	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	18,260,246	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)	1,658	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,463.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,427,295	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,911,496	22,011,031	0.223138	2,427,295	541,622	90.00
91.00	Nursing School cost	0	22,011,031	0.000000	2,427,295	0	91.00
92.00	Allied health cost	0	22,011,031	0.000000	2,427,295	0	92.00
93.00	All other Medical Education	0	22,011,031	0.000000	2,427,295	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 1:23 pm
	Title XVIII	Subprovider - IRF	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)	5,314	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,314	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)	5,314	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,471	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,769,362	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,769,362	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)	4,769,362	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)	897.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,115,257	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)	3,115,257	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,429,386	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,544,643	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)	481,879	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	97,935	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	579,814	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,964,829	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0059
Component CCN: 15-T059

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

Worksheet D-1
Date/Time Prepared:
5/28/2019 1:23 pm

Title XVIII

Subprovider - IRF

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	737,735	4,769,362	0.154682	0	0	90.00
91.00	Nursing School cost	0	4,769,362	0.000000	0	0	91.00
92.00	Allied health cost	0	4,769,362	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,769,362	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1
Component CCN: 15-5669		Date/Time Prepared: 5/28/2019 1:23 pm
Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,574	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,574	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,574	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,105	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,921,999	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,921,999	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)	3,921,999	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Component CCN: 15-5669 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	3,921,999	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	857.45	71.00
72.00	Program routine service cost (line 9 x line 71)	2,662,382	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,662,382	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,662,382	83.00
84.00	Program inpatient ancillary services (see instructions)	1,694,134	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	4,356,516	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-5669	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 1:23 pm
	Title XVIII	Skilled Nursing Facility	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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 1:23 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,035	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,035	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)	13,377	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	310	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	22,011,031	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	22,011,031	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)	22,011,031	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)	1,463.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	453,837	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)	453,837	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 1:23 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,340,647	2,792	1,912.84	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	190,215	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	644,052	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,658	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,463.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,427,295	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 1:23 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,911,496	22,011,031	0.223138	2,427,295	541,622	90.00
91.00	Nursing School cost	0	22,011,031	0.000000	2,427,295	0	91.00
92.00	Allied health cost	0	22,011,031	0.000000	2,427,295	0	92.00
93.00	All other Medical Education	0	22,011,031	0.000000	2,427,295	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 1:23 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,314	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,314	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)	5,314	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,769,362	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,769,362	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)	4,769,362	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)	897.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 1:23 pm

Title XIX | Subprovider - IRF | 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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0059
Component CCN: 15-T059

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

Worksheet D-1
Date/Time Prepared:
5/28/2019 1:23 pm

Title XIX | Subprovider - IRF | 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	737,735	4,769,362	0.154682	0	0	90.00
91.00	Nursing School cost	0	4,769,362	0.000000	0	0	91.00
92.00	Allied health cost	0	4,769,362	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,769,362	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		8,906,526		30.00
31.00	03100	INTENSIVE CARE UNIT		3,022,311		31.00
41.00	04100	SUBPROVIDER - IRF		231,010		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.131489	12,503,822	1,644,115	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.318866	841,508	268,328	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.263525	20,874	5,501	55.00
57.00	05700	CT SCAN	0.037866	1,162,747	44,029	57.00
57.01	03630	ULTRA SOUND	0.058997	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.113548	205,947	23,385	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.069850	2,036,810	142,271	59.00
60.00	06000	LABORATORY	0.199574	5,494,495	1,096,558	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.493272	301,393	148,669	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.332644	1,973,474	656,464	65.00
66.00	06600	PHYSICAL THERAPY	0.348286	1,519,776	529,317	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.225844	1,197,011	270,338	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.527305	6,727,097	3,547,232	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.066476	3,278,560	217,946	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.395776	5,355,634	2,119,631	73.00
74.00	07400	RENAL DIALYSIS	0.642185	289,163	185,696	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.216404	122,672	26,547	76.01
76.02	03070	WOMEN'S CENTER	0.156312	1,043	163	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.142336	4,320	615	90.00
90.01	09001	OUTPATIENT	0.356050	84,997	30,263	90.01
90.02	09002	NEUROPSYCHOLOGY	0.848092	0	0	90.02
91.00	09100	EMERGENCY	0.238306	2,262,571	539,184	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.646001	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)		45,383,914	11,496,252	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)		45,383,914		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		4,005,779		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.131489	134,793	17,724	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.318866	49,014	15,629	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.263525	0	0	55.00
57.00	05700	CT SCAN	0.037866	56,963	2,157	57.00
57.01	03630	ULTRA SOUND	0.058997	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.113548	19,327	2,195	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.069850	19,513	1,363	59.00
60.00	06000	LABORATORY	0.199574	728,606	145,411	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.493272	9,916	4,891	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.332644	312,976	104,110	65.00
66.00	06600	PHYSICAL THERAPY	0.348286	3,778,290	1,315,926	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.225844	38,332	8,657	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.527305	619,842	326,846	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.066476	7,802	519	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.395776	930,277	368,181	73.00
74.00	07400	RENAL DIALYSIS	0.642185	141,872	91,108	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.216404	4,890	1,058	76.01
76.02	03070	WOMEN'S CENTER	0.156312	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.142336	1,290	184	90.00
90.01	09001	OUTPATIENT	0.356050	34,500	12,284	90.01
90.02	09002	NEUROPSYCHOLOGY	0.848092	0	0	90.02
91.00	09100	EMERGENCY	0.238306	46,760	11,143	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.646001	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)		6,934,963	2,429,386	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)		6,934,963		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0059 | Component CCN: 15-5669 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.131489	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.318866	30,890	9,850	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.263525	0	0	55.00
57.00	05700	CT SCAN	0.037866	0	0	57.00
57.01	03630	ULTRA SOUND	0.058997	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.113548	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.069850	13,951	974	59.00
60.00	06000	LABORATORY	0.199574	1,047,422	209,038	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.493272	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.332644	229,106	76,211	65.00
66.00	06600	PHYSICAL THERAPY	0.348286	1,408,450	490,543	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.225844	375	85	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.527305	288,438	152,095	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.066476	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.395776	1,907,506	754,945	73.00
74.00	07400	RENAL DIALYSIS	0.642185	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.216404	1,815	393	76.01
76.02	03070	WOMEN'S CENTER	0.156312	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.142336	0	0	90.00
90.01	09001	OUTPATIENT	0.356050	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.848092	0	0	90.02
91.00	09100	EMERGENCY	0.238306	0	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.646001	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)		4,927,953	1,694,134	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)		4,927,953		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 1:23 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		870,073		30.00
31.00	03100	INTENSIVE CARE UNIT		75,401		31.00
41.00	04100	SUBPROVIDER - IRF		273		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.131489	198,906	26,154	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.318866	18,420	5,874	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.263525	0	0	55.00
57.00	05700	CT SCAN	0.037866	19,497	738	57.00
57.01	03630	ULTRA SOUND	0.058997	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.113548	8,105	920	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.069850	174,390	12,181	59.00
60.00	06000	LABORATORY	0.199574	162,836	32,498	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.493272	17,669	8,716	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.332644	27,740	9,228	65.00
66.00	06600	PHYSICAL THERAPY	0.348286	18,395	6,407	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.225844	30,886	6,975	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.527305	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.066476	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.395776	141,393	55,960	73.00
74.00	07400	RENAL DIALYSIS	0.642185	10,675	6,855	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.216404	9,615	2,081	76.01
76.02	03070	WOMEN'S CENTER	0.156312	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.142336	0	0	90.00
90.01	09001	OUTPATIENT	0.356050	4,217	1,501	90.01
90.02	09002	NEUROPSYCHOLOGY	0.848092	0	0	90.02
91.00	09100	EMERGENCY	0.238306	59,282	14,127	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.646001	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)		902,026	190,215	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)		902,026		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 1:23 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	13,703,271	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	178,713	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	101.07	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.54	30.00
31.00	Percentage of Medicaid patient days (see instructions)	14.85	31.00
32.00	Sum of lines 30 and 31	16.39	32.00
33.00	Allowable disproportionate share percentage (see instructions)	3.41	33.00
34.00	Disproportionate share adjustment (see instructions)	116,821	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 1:23 pm
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	850,363	1,096,252	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	636,025	276,316	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	912,341		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	14,911,146		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	14,911,146	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,205,408	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	32,150	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	17,240	58.00
59.00	Total (sum of amounts on lines 49 through 58)	16,165,944	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	16,165,944	61.00
62.00	Deductibles billed to program beneficiaries	1,584,980	62.00
63.00	Coinsurance billed to program beneficiaries	18,090	63.00
64.00	Allowable bad debts (see instructions)	25,541	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	16,602	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	18,989	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	14,579,476	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-1,125	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Date/Time Prepared: 5/28/2019 1:23 pm

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		14,578,351	71.00
71.01	Sequestration adjustment (see instructions)		291,567	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		14,342,612	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-55,828	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		156,796	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/28/2019 1:23 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	13,703,271	0		13,703,271	13,703,271	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	178,713	0	0	178,713	178,713	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0341	0.0341	0.0341	0.0341		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	116,821	0	0	116,821	116,821	11.00
11.01	Uncompensated care payments	36.00	912,341	0	636,025	276,316	912,341	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	14,911,146	0	636,025	14,275,121	14,911,146	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,911,146	0	636,025	14,275,121	14,911,146	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,205,408	0	0	1,205,408	1,205,408	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/28/2019 1:23 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	636,025	15,480,529	16,116,554	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,115,915	0	0	1,115,915	1,115,915	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	51,775	0	0	51,775	51,775	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0338	0.0338	0.0338	0.0338		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	37,718	0	0	37,718	37,718	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,205,408	0	0	1,205,408	1,205,408	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2019 1:23 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	13,703,271		13,703,271	13,703,271	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	178,713	0	178,713	178,713	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0341	0.0341	0.0341		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	116,821	0	116,821	116,821	11.00
11.01	Uncompensated care payments	36.00	912,341	636,025	276,316	912,341	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	14,911,146	636,025	14,275,121	14,911,146	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,911,146	636,025	14,275,121	14,911,146	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,205,408	0	1,205,408	1,205,408	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			636,025	15,480,529	16,116,554	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2019 1:23 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,115,915	0	1,115,915	1,115,915	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	51,775	0	51,775	51,775	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0338	0.0338	0.0338		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	37,718	0	37,718	37,718	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,205,408	0	1,205,408	1,205,408	26.00

		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-1,125	0	-1,125	-1,125	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01

						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 1:23 pm
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,298	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	17,860,279	2.00
3.00	OPPS payments	15,259,487	3.00
4.00	Outlier payment (see instructions)	141,183	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	52,496	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,298	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	18,439	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)	18,439	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)	18,439	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	11,141	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)	7,298	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)	15,453,166	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,868,081	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)	12,592,383	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)	12,592,383	30.00
31.00	Primary payer payments	825	31.00
32.00	Subtotal (line 30 minus line 31)	12,591,558	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)	79,629	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	51,759	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	60,173	36.00
37.00	Subtotal (see instructions)	12,643,317	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-105	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)	12,643,422	40.00
40.01	Sequestration adjustment (see instructions)	252,868	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	12,434,711	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-44,157	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: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		14,253,172		12,284,900	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	12/31/2018	89,440	12/31/2018	149,811	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)		89,440		149,811	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)		14,342,612		12,434,711	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		55,828		44,157	6.02
7.00	Total Medicare program liability (see instructions)		14,286,784		12,390,554	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: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,864,848		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)		5,864,848		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		390		0	6.02
7.00	Total Medicare program liability (see instructions)		5,864,458		0	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: 15-0059 | Component CCN: 15-5669 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2019 1:23 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,669,639		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)		1,669,639		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		6,017		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,675,656		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: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/28/2019 1:23 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part III Date/Time Prepared: 5/28/2019 1:23 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	5,946,430	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0134	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	101,684	3.00
4.00	Outlier Payments	40,378	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	14.558904	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	6,088,492	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	6,088,492	17.00
18.00	Primary payer payments	23,668	18.00
19.00	Subtotal (line 17 less line 18).	6,064,824	19.00
20.00	Deductibles	65,588	20.00
21.00	Subtotal (line 19 minus line 20)	5,999,236	21.00
22.00	Coinsurance	18,090	22.00
23.00	Subtotal (line 21 minus line 22)	5,981,146	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	5,981,146	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	2,995	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	5,984,141	32.00
32.01	Sequestration adjustment (see instructions)	119,683	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	5,864,848	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-390	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	40,378	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-5669	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VI Date/Time Prepared: 5/28/2019 1:23 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,828,836	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	6,140	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,834,976	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	125,123	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,709,853	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	1,709,853	15.00
15.01	Sequestration adjustment (see instructions)	34,197	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	1,669,639	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	6,017	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2019 1:23 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	644,052		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	644,052	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	644,052	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	945,747		8.00
9.00	Ancillary service charges	902,026	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,847,773	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,847,773	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,203,721	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	644,052	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	644,052	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	644,052	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	644,052	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	644,052	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	644,052	0	40.00
41.00	Interim payments	721,042	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-76,990	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2019 1:23 pm
	Title XIX	Subprovider - IRF	Cost

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/28/2019 1:23 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	13,683,103	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	33,927,347	0	0	0	4.00
5.00	Other receivable	282,634	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	5,205,640	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	17,242,881	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	70,341,605	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	15,961,384	0	0	0	12.00
13.00	Land improvements	2,979,163	0	0	0	13.00
14.00	Accumulated depreciation	-3,830,259	0	0	0	14.00
15.00	Buildings	133,479,199	0	0	0	15.00
16.00	Accumulated depreciation	-65,178,259	0	0	0	16.00
17.00	Leasehold improvements	1,366,441	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	78,172,904	0	0	0	19.00
20.00	Accumulated depreciation	-32,082,508	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	105,208,757	0	0	0	23.00
24.00	Accumulated depreciation	-65,512,316	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)	170,564,506	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	43,241,873	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	2,228,977	0	0	0	33.00
34.00	Other assets	6,661,360	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	52,132,210	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	293,038,321	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	8,983,198	0	0	0	37.00
38.00	Salaries, wages, and fees payable	10,950,680	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,123,970	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	69,264,892	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	94,322,740	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	64,591,165	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	207,465	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	64,798,630	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	159,121,370	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	133,916,951				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)	133,916,951	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	293,038,321	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/28/2019 1:23 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		144,439,914		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-10,522,963				2.00
3.00	Total (sum of line 1 and line 2)		133,916,951		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)		133,916,951		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)		133,916,951		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: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/28/2019 1:23 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	29,145,877		29,145,877	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	6,253,039		6,253,039	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	2,643,269		2,643,269	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)	38,042,185		38,042,185	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	7,748,707		7,748,707	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)	7,748,707		7,748,707	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	45,790,892		45,790,892	17.00
18.00	Ancillary services	122,291,622	240,114,230	362,405,852	18.00
19.00	Outpatient services	5,589,339	41,532,467	47,121,806	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS' PRIVATE OFFICES	0	48,336,592	48,336,592	27.00
27.01	CLINICS	0	1,372,558	1,372,558	27.01
27.02	PRO FEE	0	5,536,413	5,536,413	27.02
27.03	DIABETIC EDUCTION -OTHER REVENUE (RE	37,450	0	37,450	27.03
27.04	OP PHARMACY REVENUE	0	155	155	27.04
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	173,709,303	336,892,415	510,601,718	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		209,626,573		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		209,626,573		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/28/2019 1:23 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	510,601,718	1.00
2.00	Less contractual allowances and discounts on patients' accounts	321,371,356	2.00
3.00	Net patient revenues (line 1 minus line 2)	189,230,362	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	209,626,573	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-20,396,211	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-3,036,269	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	NON-OPERATING REVENUE AND EXPENSE	629,350	24.00
24.01	OTHER OPERATING REVENUE	12,280,167	24.01
25.00	Total other income (sum of lines 6-24)	9,873,248	25.00
26.00	Total (line 5 plus line 25)	-10,522,963	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)	-10,522,963	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/28/2019 1:23 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,115,915	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	51,775	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	44.95	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	1.54	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	14.85	8.00
9.00	Sum of lines 7 and 8	16.39	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.38	10.00
11.00	Disproportionate share adjustment (see instructions)	37,718	11.00
12.00	Total prospective capital payments (see instructions)	1,205,408	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00