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: 15-1304	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/24/2019 4:59 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/24/2019 Time: 4:59 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 RUSH MEMORIAL HOSPITAL (15-1304) 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	274,228	440,281	0	206,662	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	40,295	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	314,523	440,281	0	206,662	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: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2019 4:59 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1300 NORTH MAIN STREET	PO Box:			1.00
2.00	City: RUSHVILLE	State: IN	Zip Code: 46173-	County: RUSH	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	RUSH MEMORIAL HOSPITAL	151304	99915	1	08/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	RUSH SWING BEDS	15Z304	99915		08/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0			23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2019 4:59 pm

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1304	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/24/2019 4:59 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1304	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/24/2019 4:59 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1304	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/24/2019 4:59 pm

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	135,109	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			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2019 4:59 pm

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	1	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1304	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/24/2019 4:59 pm

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1304	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/24/2019 4:59 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LANDON	HACKETT	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7929	LHACKETT@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1304	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/24/2019 4:59 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.	SENIOR MANAGER		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: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2019 4:59 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	25	9,125	30,432.00	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)		25	9,125	30,432.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	30,432.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2019 4:59 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)	870	114	1,268			1.00
2.00	HMO and other (see instructions)	0	3				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	58	0	58			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	17			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	928	114	1,343			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)	928	114	1,343	0.00	272.77	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	272.77	27.00
28.00	Observation Bed Days		0	681			28.00
29.00	Ambulance Trips	364					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2019 4:59 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	269	35	381	1.00
2.00	HMO and other (see instructions)			0	2		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	269	35	381	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/24/2019 4:59 pm

Line	Description	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)	0.362252	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,640,797	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	11,618,177	6.00
7.00	Medicaid cost (line 1 times line 6)	4,208,708	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,567,911	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	295,037	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,567,911	19.00

Line	Description	Uninsured patients 1.00	Insured patients 2.00	Total (col. 1 + col. 2) 3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	127,247	0	127,247	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	46,095	0	46,095	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)	46,095	0	46,095	23.00

Line	Description	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)	4,071,164	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	166,717	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	256,487	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,814,677	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,471,644	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,517,739	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,085,650	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/24/2019 4:59 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		2,179,496	2,179,496	0	2,179,496	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	403,556	3,915,284	4,318,840	5,553	4,324,393	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,401,999	2,729,949	5,131,948	16,779	5,148,727	5.00
7.00	00700	OPERATION OF PLANT	323,488	879,986	1,203,474	22,641	1,226,115	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	68,908	68,908	8.00
9.00	00900	HOUSEKEEPING	364,868	218,432	583,300	-46,592	536,708	9.00
10.00	01000	DIETARY	348,878	202,377	551,255	-407,648	143,607	10.00
11.00	01100	CAFETERIA	0	0	0	429,791	429,791	11.00
13.00	01300	NURSING ADMINISTRATION	111,859	380	112,239	-111,859	380	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	63,494	90,042	153,536	-170	153,366	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	346,179	55,660	401,839	0	401,839	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,670,443	105,308	1,775,751	-710,675	1,065,076	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	817,174	565,235	1,382,409	-320,795	1,061,614	50.00
51.00	05100	RECOVERY ROOM	0	5,578	5,578	25,079	30,657	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,039,452	567,020	1,606,472	-9,275	1,597,197	54.00
54.01	05401	ONCOLOGY	301,248	443,331	744,579	0	744,579	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	617,960	885,086	1,503,046	-21	1,503,025	60.00
65.00	06500	RESPIRATORY THERAPY	88,186	18,477	106,663	0	106,663	65.00
66.00	06600	PHYSICAL THERAPY	274,046	15,492	289,538	29,781	319,319	66.00
67.00	06700	OCCUPATIONAL THERAPY	205,415	2,181	207,596	29,870	237,466	67.00
68.00	06800	SPEECH PATHOLOGY	110,413	11,908	122,321	-59,788	62,533	68.00
69.00	06900	ELECTROCARDIOLOGY	124,927	1,870	126,797	-263	126,534	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	384,501	384,501	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	83,396	83,396	0	83,396	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	551,592	3,939,131	4,490,723	-3,159	4,487,564	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,364,679	148,399	2,513,078	707,451	3,220,529	90.00
90.01	09001	SURGICAL ASSOCIATES	66,212	554,290	620,502	-595	619,907	90.01
90.02	09002	ORTHOPAEDICS	12,848	145,954	158,802	-121	158,681	90.02
90.03	09003	RHEUMATOLOGY	520,539	10,891	531,430	-597	530,833	90.03
90.04	09004	ENDOCRINOLOGY	174,976	168,087	343,063	-8,247	334,816	90.04
90.05	09005	PEDIATRICS	307,185	13,937	321,122	-37	321,085	90.05
90.06	09006	WOMEN'S HEALTH	261,449	10,486	271,935	-5,142	266,793	90.06
90.07	09007	PAIN MANAGEMENT	457,749	9,578	467,327	0	467,327	90.07
91.00	09100	EMERGENCY	849,524	1,206,973	2,056,497	-33,955	2,022,542	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	391,433	47,528	438,961	-1,415	437,546	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,571,771	19,231,742	34,803,513	0	34,803,513	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	64,630	15	64,645	0	64,645	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	15,636,401	19,231,757	34,868,158	0	34,868,158	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/24/2019 4:59 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	-176,736	2,002,760	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-211,902	4,112,491	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,254,381	3,894,346	5.00
7.00	00700	OPERATION OF PLANT	-762	1,225,353	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,908	8.00
9.00	00900	HOUSEKEEPING	-396	536,312	9.00
10.00	01000	DIETARY	-2,359	141,248	10.00
11.00	01100	CAFETERIA	-247,634	182,157	11.00
13.00	01300	NURSING ADMINISTRATION	-380	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-520	152,846	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,965	395,874	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,005	1,064,071	30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-571,595	490,019	50.00
51.00	05100	RECOVERY ROOM	0	30,657	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-704,811	892,386	54.00
54.01	05401	ONCOLOGY	-375,000	369,579	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	-2,324	1,500,701	60.00
65.00	06500	RESPIRATORY THERAPY	0	106,663	65.00
66.00	06600	PHYSICAL THERAPY	0	319,319	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	237,466	67.00
68.00	06800	SPEECH PATHOLOGY	0	62,533	68.00
69.00	06900	ELECTROCARDIOLOGY	-23	126,511	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-3,313	381,188	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	83,396	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-74,482	4,413,082	73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-2,704,392	516,137	90.00
90.01	09001	SURGICAL ASSOCIATES	-541,630	78,277	90.01
90.02	09002	ORTHOPAEDICS	-126,963	31,718	90.02
90.03	09003	RHEUMATOLOGY	-529,323	1,510	90.03
90.04	09004	ENDOCRINOLOGY	-229,993	104,823	90.04
90.05	09005	PEDIATRICS	-243,080	78,005	90.05
90.06	09006	WOMEN'S HEALTH	-279,159	-12,366	90.06
90.07	09007	PAIN MANAGEMENT	-466,087	1,240	90.07
91.00	09100	EMERGENCY	0	2,022,542	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	437,546	95.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,754,215	26,049,298	118.00
	NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	FOUNDATION	0	64,645	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,754,215	26,113,943	200.00

RECLASSIFICATIONS | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/24/2019 4:59 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LAUNDRY AND LINEN				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	68,908	1.00
	0		0	68,908	
	B - DIETARY/ CAFETERIA				
1.00	CAFETERIA	11.00	272,006	157,785	1.00
	0		272,006	157,785	
	C - MED SUPPLY RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	384,501	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
	0		0	384,501	
	D - AMBULANCE RECLASS				
1.00	OPERATION OF PLANT	7.00	269	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	94	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	20	0	3.00
4.00	EMERGENCY	91.00	221	0	4.00
	0		604	0	
	E - SALARY RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	5,592	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	16,779	0	2.00
3.00	OPERATION OF PLANT	7.00	22,372	0	3.00
4.00	HOUSEKEEPING	9.00	22,372	0	4.00
5.00	DIETARY	10.00	22,372	0	5.00
6.00	RECOVERY ROOM	51.00	29,384	0	6.00
7.00	PHYSICAL THERAPY	66.00	29,894	0	7.00
8.00	OCCUPATIONAL THERAPY	67.00	29,894	0	8.00
9.00	CLINIC	90.00	22,372	0	9.00
	0		201,031	0	
	F - PHYSICIAN RECLASS				
1.00	CLINIC	90.00	689,692	0	1.00
	0		689,692	0	
500.00	Grand Total: Increases		1,163,333	611,194	500.00

RECLASSIFICATIONS | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/24/2019 4:59 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - LAUNDRY AND LINEN					
1.00	HOUSEKEEPING	9.00	0	68,908	0	1.00
	0		0	68,908		
	B - DIETARY/ CAFETERIA					
1.00	DIETARY	10.00	272,006	157,785	0	1.00
	0		272,006	157,785		
	C - MED SUPPLY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39	0	1.00
2.00	HOUSEKEEPING	9.00	0	56	0	2.00
3.00	DIETARY	10.00	0	229	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	170	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	21,077	0	5.00
6.00	OPERATING ROOM	50.00	0	291,411	0	6.00
7.00	RECOVERY ROOM	51.00	0	4,305	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,295	0	8.00
9.00	LABORATORY	60.00	0	21	0	9.00
10.00	PHYSICAL THERAPY	66.00	0	113	0	10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	24	0	11.00
12.00	ELECTROCARDIOLOGY	69.00	0	263	0	12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,159	0	13.00
14.00	CLINIC	90.00	0	1,847	0	14.00
15.00	SURGICAL ASSOCIATES	90.01	0	595	0	15.00
16.00	ORTHOPAEDICS	90.02	0	121	0	16.00
17.00	RHEUMATOLOGY	90.03	0	597	0	17.00
18.00	ENDOCRINOLOGY	90.04	0	8,247	0	18.00
19.00	PEDIATRICS	90.05	0	37	0	19.00
20.00	WOMEN'S HEALTH	90.06	0	5,142	0	20.00
21.00	CLINIC	90.00	0	2,766	0	21.00
22.00	EMERGENCY	91.00	0	34,176	0	22.00
23.00	AMBULANCE SERVICES	95.00	0	811	0	23.00
	0		0	384,501		
	D - AMBULANCE RECLASS					
1.00	AMBULANCE SERVICES	95.00	604	0	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
	0		604	0		
	E - SALARY RECLASS					
1.00	NURSING ADMINISTRATION	13.00	111,859	0	0	1.00
2.00	OPERATING ROOM	50.00	29,384	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	59,788	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
9.00		0.00	0	0	0	9.00
	0		201,031	0		
	F - PHYSICIAN RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	689,692	0	0	1.00
	0		689,692	0		
500.00	Grand Total: Decreases		1,163,333	611,194		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2019 4:59 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	188,708	0	0	0	0	1.00
2.00	Land Improvements	455,968	0	0	0	0	2.00
3.00	Buildings and Fixtures	16,823,696	1,659,095	0	1,659,095	13,742	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,946,813	843,094	0	843,094	2,041,579	5.00
6.00	Movable Equipment	15,503,070	1,327,113	0	1,327,113	465,136	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,918,255	3,829,302	0	3,829,302	2,520,457	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	35,918,255	3,829,302	0	3,829,302	2,520,457	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	188,708	0	1.00
2.00	Land Improvements	455,968	0	2.00
3.00	Buildings and Fixtures	18,469,049	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,748,328	0	5.00
6.00	Movable Equipment	16,365,047	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,227,100	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	37,227,100	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2019 4:59 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	1,741,632	0	206,516	231,348	0	1.00
3.00	Total (sum of lines 1-2)	1,741,632	0	206,516	231,348	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	2,179,496	1.00
3.00	Total (sum of lines 1-2)	0	2,179,496	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2019 4:59 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	37,227,100	0	37,227,100	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	37,227,100	0	37,227,100	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,724,188	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,724,188	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	47,224	231,348	0	0	2,002,760	1.00
3.00	Total (sum of lines 1-2)	47,224	231,348	0	0	2,002,760	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/24/2019 4:59 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	-6,649,611			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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
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	A	-17,444	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/24/2019 4:59 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	CAFETERIA	B	-100,046	CAFETERIA	11.00	0	33.00
33.01	JAIL MEALS	B	-147,588	CAFETERIA	11.00	0	33.01
33.02	VENDING MACHINES	B	-470	ADMINISTRATIVE & GENERAL	5.00	0	33.02
34.00	SALE OF DRUGS	B	-10,536	DRUGS CHARGED TO PATIENTS	73.00	0	34.00
35.00	SALE OF SUPPLIES	B	-443	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	35.00
37.00	PHYSICIAN RECRUITMENTS	B	-26,200	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01	NSF FEES	B	-334	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.01
38.00	MEDICAL RECORDS TRANSCRIPTION FEES	B	-5,965	MEDICAL RECORDS & LIBRARY	16.00	0	38.00
41.00	COPIER FEES	B	-13,546	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	ATHLETIC TRAINER - SCHOOL REV	B	-9,025	ADMINISTRATIVE & GENERAL	5.00	0	42.00
42.01	SALE OF PODIATRY SUPPLIES	B	-2,870	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	42.01
45.00	OCCUPATIONAL HEALTH	B	-75,190	CLINIC	90.00	0	45.00
45.01	MISC. INCOME	B	-207	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	MISC. INCOME	B	-20	DIETARY	10.00	0	45.02
45.03	MISC. INCOME	B	-1,998	LABORATORY	60.00	0	45.03
45.04	MISC. INCOME	B	-46,284	RHEUMATOLOGY	90.03	0	45.04
45.08	INTEREST INCOME	B	-159,292	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	45.08
45.09	TELEPHONE SALARY	B	-5,086	ADMINISTRATIVE & GENERAL	5.00	0	45.09
45.10	TELEPHONE OTHER	A	-1,149	ADMINISTRATIVE & GENERAL	5.00	0	45.10
45.11	TELEPHONE BENEFITS	A	-807	ADMINISTRATIVE & GENERAL	5.00	0	45.11
45.12	ADVERTISING	A	-211,064	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.12
45.13	IHA & AHA LOBBYING	A	-3,630	ADMINISTRATIVE & GENERAL	5.00	0	45.13
45.14	REBATES	A	-504	EMPLOYEE BENEFITS DEPARTMENT	4.00	9	45.14
45.15	REBATES	B	-12,558	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	REBATES	B	-762	OPERATION OF PLANT	7.00	0	45.16
45.17	REBATES	B	-396	HOUSEKEEPING	9.00	0	45.17
45.18	REBATES	B	-2,339	DIETARY	10.00	0	45.18
45.19	REBATES	B	-380	NURSING ADMINISTRATION	13.00	0	45.19
45.20	REBATES	B	-520	CENTRAL SERVICES & SUPPLY	14.00	0	45.20
45.25	REBATES	B	-1,005	ADULTS & PEDIATRICS	30.00	0	45.25
45.26	REBATES	B	-584	OPERATING ROOM	50.00	0	45.26
46.00	REBATES	B	-235	RADIOLOGY-DIAGNOSTIC	54.00	0	46.00
46.01	REBATES	B	-326	LABORATORY	60.00	0	46.01
46.02	REBATES	B	-23	ELECTROCARDIOLOGY	69.00	0	46.02
46.03	REBATES	B	-63,946	DRUGS CHARGED TO PATIENTS	73.00	0	46.03
46.04	REBATES	B	-129	RHEUMATOLOGY	90.03	0	46.04
46.05	HAF EXPENSE	B	-1,180,982	ADMINISTRATIVE & GENERAL	5.00	0	46.05
46.07	SAFE SITTER CLASS FEES	A	-721	ADMINISTRATIVE & GENERAL	5.00	0	46.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,754,215				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2019 4:59 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	50.00	OPERATING ROOM	594,343	571,011	23,332	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	729,887	704,576	25,311	0	0	2.00
3.00	60.00	LABORATORY	37,200	0	37,200	0	0	3.00
4.00	90.00	CLINIC	2,723,193	2,629,202	93,991	0	0	4.00
5.00	90.01	SURGICAL ASSOCIATES	550,000	541,630	8,370	0	0	5.00
6.00	90.02	ORTHOPAEDICS	140,499	126,963	13,536	0	0	6.00
7.00	90.03	RHEUMATOLOGY	506,587	482,910	23,677	0	0	7.00
8.00	90.04	ENDOCRINOLOGY	290,378	229,993	60,385	0	0	8.00
9.00	90.05	PEDIATRICS	253,166	243,080	10,086	0	0	9.00
10.00	90.06	WOMEN'S HEALTH	294,136	279,159	14,977	0	0	10.00
11.00	90.07	PAIN MANAGEMENT	480,104	466,087	14,017	0	0	11.00
12.00	91.00	EMERGENCY	1,118,839	0	1,118,839	0	0	12.00
13.00	54.01	ONCOLOGY	400,000	375,000	25,000	0	0	13.00
200.00			8,118,332	6,649,611	1,468,721		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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	90.01	SURGICAL ASSOCIATES	0	0	0	0	0	5.00
6.00	90.02	ORTHOPAEDICS	0	0	0	0	0	6.00
7.00	90.03	RHEUMATOLOGY	0	0	0	0	0	7.00
8.00	90.04	ENDOCRINOLOGY	0	0	0	0	0	8.00
9.00	90.05	PEDIATRICS	0	0	0	0	0	9.00
10.00	90.06	WOMEN'S HEALTH	0	0	0	0	0	10.00
11.00	90.07	PAIN MANAGEMENT	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
13.00	54.01	ONCOLOGY	0	0	0	0	0	13.00
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	50.00	OPERATING ROOM	0	0	0	571,011	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	704,576	2.00
3.00	60.00	LABORATORY	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	2,629,202	4.00
5.00	90.01	SURGICAL ASSOCIATES	0	0	0	541,630	5.00
6.00	90.02	ORTHOPAEDICS	0	0	0	126,963	6.00
7.00	90.03	RHEUMATOLOGY	0	0	0	482,910	7.00
8.00	90.04	ENDOCRINOLOGY	0	0	0	229,993	8.00
9.00	90.05	PEDIATRICS	0	0	0	243,080	9.00
10.00	90.06	WOMEN'S HEALTH	0	0	0	279,159	10.00
11.00	90.07	PAIN MANAGEMENT	0	0	0	466,087	11.00
12.00	91.00	EMERGENCY	0	0	0	0	12.00
13.00	54.01	ONCOLOGY	0	0	0	375,000	13.00
200.00			0	0	0	6,649,611	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/24/2019 4:59 pm

Speech Pathology | Cost

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

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	203.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	75.55	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.78	37.78	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	15,356	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	15,356	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	15,356	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	15,356	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/24/2019 4:59 pm

Speech Pathology | Cost

		1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	75.55	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	15,356	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	15,356	63.00
64.00	Total cost of outside supplier services (from your records)	10,834	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/24/2019 4:59 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	2,002,760	2,002,760				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,112,491	15,530	4,128,021			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,894,346	295,323	655,716	4,845,385	4,845,385	5.00
7.00	00700	OPERATION OF PLANT	1,225,353	156,301	93,833	1,475,487	336,144	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	68,908	15,367	0	84,275	19,199	8.00
9.00	00900	HOUSEKEEPING	536,312	33,671	104,978	674,961	153,769	9.00
10.00	01000	DIETARY	141,248	64,894	26,904	233,046	53,092	10.00
11.00	01100	CAFETERIA	182,157	21,569	73,739	277,465	63,212	11.00
13.00	01300	NURSING ADMINISTRATION	0	14,341	0	14,341	3,267	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	152,846	46,100	17,213	216,159	49,245	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	395,874	30,500	93,847	520,221	118,516	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,064,071	154,062	265,901	1,484,034	338,091	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	490,019	126,570	213,565	830,154	189,125	50.00
51.00	05100	RECOVERY ROOM	30,657	14,644	7,966	53,267	12,135	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	892,386	123,422	281,795	1,297,603	295,619	54.00
54.01	05401	ONCOLOGY	369,579	48,618	81,667	499,864	113,879	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	1,500,701	48,525	167,525	1,716,751	391,108	60.00
65.00	06500	RESPIRATORY THERAPY	106,663	3,055	23,907	133,625	30,442	65.00
66.00	06600	PHYSICAL THERAPY	319,319	87,139	82,396	488,854	111,370	66.00
67.00	06700	OCCUPATIONAL THERAPY	237,466	20,123	63,791	321,380	73,216	67.00
68.00	06800	SPEECH PATHOLOGY	62,533	4,221	13,724	80,478	18,334	68.00
69.00	06900	ELECTROCARDIOLOGY	126,511	9,374	33,867	169,752	38,673	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	381,188	0	0	381,188	86,842	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	83,396	0	0	83,396	18,999	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,413,082	8,301	149,533	4,570,916	1,041,347	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	516,137	302,316	834,092	1,652,545	376,481	90.00
90.01	09001	SURGICAL ASSOCIATES	78,277	36,609	17,950	132,836	30,263	90.01
90.02	09002	ORTHOPAEDICS	31,718	25,137	3,483	60,338	13,746	90.02
90.03	09003	RHEUMATOLOGY	1,510	33,555	141,115	176,180	40,137	90.03
90.04	09004	ENDOCRINOLOGY	104,823	8,394	47,435	160,652	36,600	90.04
90.05	09005	PEDIATRICS	78,005	33,321	83,276	194,602	44,334	90.05
90.06	09006	WOMEN'S HEALTH	-12,366	25,067	70,877	83,578	19,041	90.06
90.07	09007	PAIN MANAGEMENT	1,240	0	124,093	125,333	28,553	90.07
91.00	09100	EMERGENCY	2,022,542	89,961	230,361	2,342,864	533,749	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	437,546	86,930	105,951	630,427	143,623	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,049,298	1,982,940	4,110,500	26,011,957	4,822,151	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	64,645	19,820	17,521	101,986	23,234	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE	0	0	0	0	0	194.00
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)	26,113,943	2,002,760	4,128,021	26,113,943	4,845,385	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/24/2019 4:59 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	1,811,631					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,129	121,603				8.00
9.00	00900	HOUSEKEEPING	39,724	8,535	876,989			9.00
10.00	01000	DIETARY	76,559	3,499	38,284	404,480		10.00
11.00	01100	CAFETERIA	25,446	0	12,725	0	378,848	11.00
13.00	01300	NURSING ADMINISTRATION	16,918	0	8,460	0	2,031	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	54,386	0	27,196	0	4,469	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,982	0	17,993	0	23,157	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	181,755	79,291	90,888	404,480	41,237	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	149,321	7,959	74,669	0	18,282	50.00
51.00	05100	RECOVERY ROOM	17,276	0	8,639	0	1,625	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	145,607	5,142	72,812	0	25,392	54.00
54.01	05401	ONCOLOGY	57,357	0	28,682	0	15,032	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	57,247	0	28,627	0	27,220	60.00
65.00	06500	RESPIRATORY THERAPY	3,604	1,024	1,802	0	3,656	65.00
66.00	06600	PHYSICAL THERAPY	102,803	2,394	51,407	0	10,360	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,741	1,101	11,872	0	5,688	67.00
68.00	06800	SPEECH PATHOLOGY	4,979	47	2,490	0	2,438	68.00
69.00	06900	ELECTROCARDIOLOGY	11,059	0	5,530	0	6,297	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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	9,793	0	4,897	0	15,438	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	356,658	0	178,349	0	80,442	90.00
90.01	09001	SURGICAL ASSOCIATES	43,190	0	21,597	0	5,688	90.01
90.02	09002	ORTHOPAEDICS	29,655	0	14,829	0	1,219	90.02
90.03	09003	RHEUMATOLOGY	39,586	0	19,795	0	9,954	90.03
90.04	09004	ENDOCRINOLOGY	9,903	0	4,952	0	8,938	90.04
90.05	09005	PEDIATRICS	39,311	0	19,658	0	6,094	90.05
90.06	09006	WOMEN'S HEALTH	29,573	0	14,788	0	4,063	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	0	6,094	90.07
91.00	09100	EMERGENCY	106,131	12,611	53,072	0	40,627	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	102,555	0	51,283	0	11,782	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,788,248	121,603	865,296	404,480	377,223	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	23,383	0	11,693	0	1,625	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,811,631	121,603	876,989	404,480	378,848	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/24/2019 4:59 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
		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	45,017					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	351,455				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	363	716,232			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,485	16,280	307,737	2,951,278	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,402	91,135	0	1,364,047	0	50.00
51.00	05100	RECOVERY ROOM	331	319	67,678	161,270	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,223	8,792	81,942	1,938,132	0	54.00
54.01	05401	ONCOLOGY	3,111	3,307	0	721,232	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	5,602	136,081	0	2,362,636	0	60.00
65.00	06500	RESPIRATORY THERAPY	774	961	1,517	177,405	0	65.00
66.00	06600	PHYSICAL THERAPY	2,281	1,062	0	770,531	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,309	231	0	438,538	0	67.00
68.00	06800	SPEECH PATHOLOGY	231	175	0	109,172	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,292	391	0	232,994	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,338	0	491,368	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	20,908	0	123,303	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,168	5,153	0	5,650,712	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	16,306	0	2,660,781	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	605	0	234,179	0	90.01
90.02	09002	ORTHOPAEDICS	0	149	0	119,936	0	90.02
90.03	09003	RHEUMATOLOGY	0	753	0	286,405	0	90.03
90.04	09004	ENDOCRINOLOGY	0	7,058	0	228,103	0	90.04
90.05	09005	PEDIATRICS	0	2,139	0	306,138	0	90.05
90.06	09006	WOMEN'S HEALTH	0	646	0	151,689	0	90.06
90.07	09007	PAIN MANAGEMENT	0	707	0	160,687	0	90.07
91.00	09100	EMERGENCY	8,399	11,049	257,358	3,365,860	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,409	3,547	0	945,626	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,017	351,455	716,232	25,952,022	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	0	0	161,921	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	45,017	351,455	716,232	26,113,943	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/24/2019 4:59 pm

		Cost Center Description	Total		
			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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,951,278		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,364,047		50.00
51.00	05100	RECOVERY ROOM	161,270		51.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,938,132		54.00
54.01	05401	ONCOLOGY	721,232		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		55.00
60.00	06000	LABORATORY	2,362,636		60.00
65.00	06500	RESPIRATORY THERAPY	177,405		65.00
66.00	06600	PHYSICAL THERAPY	770,531		66.00
67.00	06700	OCCUPATIONAL THERAPY	438,538		67.00
68.00	06800	SPEECH PATHOLOGY	109,172		68.00
69.00	06900	ELECTROCARDIOLOGY	232,994		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	491,368		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	123,303		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,650,712		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	2,660,781		90.00
90.01	09001	SURGICAL ASSOCIATES	234,179		90.01
90.02	09002	ORTHOPAEDICS	119,936		90.02
90.03	09003	RHEUMATOLOGY	286,405		90.03
90.04	09004	ENDOCRINOLOGY	228,103		90.04
90.05	09005	PEDIATRICS	306,138		90.05
90.06	09006	WOMEN'S HEALTH	151,689		90.06
90.07	09007	PAIN MANAGEMENT	160,687		90.07
91.00	09100	EMERGENCY	3,365,860		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	945,626		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,952,022		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
193.01	19301	FOUNDATION	161,921		193.01
193.02	19302	OCCUPATIONAL MEDICINE	0		193.02
194.00	07950	OTHER NON REIMBURSABLE	0		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	26,113,943		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/24/2019 4:59 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	15,530	15,530	15,530		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	295,323	295,323	2,467	297,790	5.00
7.00	00700	OPERATION OF PLANT	0	156,301	156,301	353	20,658	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,367	15,367	0	1,180	8.00
9.00	00900	HOUSEKEEPING	0	33,671	33,671	395	9,450	9.00
10.00	01000	DIETARY	0	64,894	64,894	101	3,263	10.00
11.00	01100	CAFETERIA	0	21,569	21,569	277	3,885	11.00
13.00	01300	NURSING ADMINISTRATION	0	14,341	14,341	0	201	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	46,100	46,100	65	3,026	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,500	30,500	353	7,284	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	154,062	154,062	1,000	20,778	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	126,570	126,570	804	11,623	50.00
51.00	05100	RECOVERY ROOM	0	14,644	14,644	30	746	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	123,422	123,422	1,060	18,168	54.00
54.01	05401	ONCOLOGY	0	48,618	48,618	307	6,999	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	48,525	48,525	630	24,036	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,055	3,055	90	1,871	65.00
66.00	06600	PHYSICAL THERAPY	0	87,139	87,139	310	6,844	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	20,123	20,123	240	4,500	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,221	4,221	52	1,127	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,374	9,374	127	2,377	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,337	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,168	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,301	8,301	563	64,004	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	302,316	302,316	3,137	23,137	90.00
90.01	09001	SURGICAL ASSOCIATES	0	36,609	36,609	68	1,860	90.01
90.02	09002	ORTHOPAEDICS	0	25,137	25,137	13	845	90.02
90.03	09003	RHEUMATOLOGY	0	33,555	33,555	531	2,467	90.03
90.04	09004	ENDOCRINOLOGY	0	8,394	8,394	178	2,249	90.04
90.05	09005	PEDIATRICS	0	33,321	33,321	313	2,725	90.05
90.06	09006	WOMEN'S HEALTH	0	25,067	25,067	267	1,170	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	467	1,755	90.07
91.00	09100	EMERGENCY	0	89,961	89,961	867	32,802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	86,930	86,930	399	8,827	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,982,940	1,982,940	15,464	296,362	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	19,820	19,820	66	1,428	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE	0	0	0	0	0	194.00
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	2,002,760	2,002,760	15,530	297,790	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/24/2019 4:59 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	177,312					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,774	18,321				8.00
9.00	00900	HOUSEKEEPING	3,888	1,286	48,690			9.00
10.00	01000	DIETARY	7,493	527	2,125	78,403		10.00
11.00	01100	CAFETERIA	2,491	0	706	0	28,928	11.00
13.00	01300	NURSING ADMINISTRATION	1,656	0	470	0	155	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,323	0	1,510	0	341	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,522	0	999	0	1,768	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,789	11,946	5,046	78,403	3,149	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,615	1,199	4,146	0	1,396	50.00
51.00	05100	RECOVERY ROOM	1,691	0	480	0	124	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,251	775	4,042	0	1,939	54.00
54.01	05401	ONCOLOGY	5,614	0	1,592	0	1,148	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	5,603	0	1,589	0	2,078	60.00
65.00	06500	RESPIRATORY THERAPY	353	154	100	0	279	65.00
66.00	06600	PHYSICAL THERAPY	10,062	361	2,854	0	791	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,324	166	659	0	434	67.00
68.00	06800	SPEECH PATHOLOGY	487	7	138	0	186	68.00
69.00	06900	ELECTROCARDIOLOGY	1,082	0	307	0	481	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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	959	0	272	0	1,179	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	34,907	0	9,904	0	6,145	90.00
90.01	09001	SURGICAL ASSOCIATES	4,227	0	1,199	0	434	90.01
90.02	09002	ORTHOPAEDICS	2,902	0	823	0	93	90.02
90.03	09003	RHEUMATOLOGY	3,874	0	1,099	0	760	90.03
90.04	09004	ENDOCRINOLOGY	969	0	275	0	682	90.04
90.05	09005	PEDIATRICS	3,848	0	1,091	0	465	90.05
90.06	09006	WOMEN'S HEALTH	2,894	0	821	0	310	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	0	465	90.07
91.00	09100	EMERGENCY	10,388	1,900	2,947	0	3,102	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	10,037	0	2,847	0	900	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	175,023	18,321	48,041	78,403	28,804	118.00
	NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	2,289	0	649	0	124	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE	0	0	0	0	0	194.00
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)	177,312	18,321	48,690	78,403	28,928	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/24/2019 4:59 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
		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	16,823					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	56,365				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	58	44,484			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,797	2,611	19,114	316,695	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,271	14,616	0	176,240	0	50.00
51.00	05100	RECOVERY ROOM	124	51	4,203	22,093	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,952	1,410	5,089	172,108	0	54.00
54.01	05401	ONCOLOGY	1,162	530	0	65,970	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	2,094	21,825	0	106,380	0	60.00
65.00	06500	RESPIRATORY THERAPY	289	154	94	6,439	0	65.00
66.00	06600	PHYSICAL THERAPY	852	170	0	109,383	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	489	37	0	28,972	0	67.00
68.00	06800	SPEECH PATHOLOGY	86	28	0	6,332	0	68.00
69.00	06900	ELECTROCARDIOLOGY	483	63	0	14,294	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,743	0	9,080	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,353	0	4,521	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,184	826	0	77,288	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,615	0	382,161	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	97	0	44,494	0	90.01
90.02	09002	ORTHOPAEDICS	0	24	0	29,837	0	90.02
90.03	09003	RHEUMATOLOGY	0	121	0	42,407	0	90.03
90.04	09004	ENDOCRINOLOGY	0	1,132	0	13,879	0	90.04
90.05	09005	PEDIATRICS	0	343	0	42,106	0	90.05
90.06	09006	WOMEN'S HEALTH	0	104	0	30,633	0	90.06
90.07	09007	PAIN MANAGEMENT	0	113	0	2,800	0	90.07
91.00	09100	EMERGENCY	3,140	1,772	15,984	162,863	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	900	569	0	111,409	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,823	56,365	44,484	1,978,384	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	0	0	24,376	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,823	56,365	44,484	2,002,760	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/24/2019 4:59 pm

		Cost Center Description	Total	
			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
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	316,695	30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	176,240	50.00
51.00	05100	RECOVERY ROOM	22,093	51.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	172,108	54.00
54.01	05401	ONCOLOGY	65,970	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
60.00	06000	LABORATORY	106,380	60.00
65.00	06500	RESPIRATORY THERAPY	6,439	65.00
66.00	06600	PHYSICAL THERAPY	109,383	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,972	67.00
68.00	06800	SPEECH PATHOLOGY	6,332	68.00
69.00	06900	ELECTROCARDIOLOGY	14,294	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,080	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,521	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,288	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	382,161	90.00
90.01	09001	SURGICAL ASSOCIATES	44,494	90.01
90.02	09002	ORTHOPAEDICS	29,837	90.02
90.03	09003	RHEUMATOLOGY	42,407	90.03
90.04	09004	ENDOCRINOLOGY	13,879	90.04
90.05	09005	PEDIATRICS	42,106	90.05
90.06	09006	WOMEN'S HEALTH	30,633	90.06
90.07	09007	PAIN MANAGEMENT	2,800	90.07
91.00	09100	EMERGENCY	162,863	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	111,409	95.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,978,384	118.00
		NONREIMBURSABLE COST CENTERS		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
193.01	19301	FOUNDATION	24,376	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	193.02
194.00	07950	OTHER NON REIMBURSABLE	0	194.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,002,760	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 4:59 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	85,889					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	666	15,227,253				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,665	2,418,778	-4,845,385	21,268,558		5.00
7.00	00700	OPERATION OF PLANT	6,703	346,129	0	1,475,487	65,855	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	659	0	0	84,275	659	8.00
9.00	00900	HOUSEKEEPING	1,444	387,240	0	674,961	1,444	9.00
10.00	01000	DIETARY	2,783	99,244	0	233,046	2,783	10.00
11.00	01100	CAFETERIA	925	272,006	0	277,465	925	11.00
13.00	01300	NURSING ADMINISTRATION	615	0	0	14,341	615	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,977	63,494	0	216,159	1,977	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,308	346,179	0	520,221	1,308	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,607	980,845	0	1,484,034	6,607	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,428	787,790	0	830,154	5,428	50.00
51.00	05100	RECOVERY ROOM	628	29,384	0	53,267	628	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,293	1,039,472	0	1,297,603	5,293	54.00
54.01	05401	ONCOLOGY	2,085	301,248	0	499,864	2,085	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	2,081	617,960	0	1,716,751	2,081	60.00
65.00	06500	RESPIRATORY THERAPY	131	88,186	0	133,625	131	65.00
66.00	06600	PHYSICAL THERAPY	3,737	303,940	0	488,854	3,737	66.00
67.00	06700	OCCUPATIONAL THERAPY	863	235,309	0	321,380	863	67.00
68.00	06800	SPEECH PATHOLOGY	181	50,625	0	80,478	181	68.00
69.00	06900	ELECTROCARDIOLOGY	402	124,927	0	169,752	402	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	381,188	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	83,396	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	356	551,592	0	4,570,916	356	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,965	3,076,743	0	1,652,545	12,965	90.00
90.01	09001	SURGICAL ASSOCIATES	1,570	66,212	0	132,836	1,570	90.01
90.02	09002	ORTHOPAEDICS	1,078	12,848	0	60,338	1,078	90.02
90.03	09003	RHEUMATOLOGY	1,439	520,539	0	176,180	1,439	90.03
90.04	09004	ENDOCRINOLOGY	360	174,976	0	160,652	360	90.04
90.05	09005	PEDIATRICS	1,429	307,185	0	194,602	1,429	90.05
90.06	09006	WOMEN'S HEALTH	1,075	261,449	0	83,578	1,075	90.06
90.07	09007	PAIN MANAGEMENT	0	457,749	0	125,333	0	90.07
91.00	09100	EMERGENCY	3,858	849,745	0	2,342,864	3,858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,728	390,829	0	630,427	3,728	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,039	15,162,623	-4,845,385	21,166,572	65,005	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	850	64,630	0	101,986	850	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE	0	0	0	0	0	194.00
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)	2,002,760	4,128,021		4,845,385	1,811,631	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.318003	0.271094		0.227819	27.509392	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		15,530		297,790	177,312	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001020		0.014001	2.692461	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: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 4:59 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	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	28,495					8.00
9.00	00900	HOUSEKEEPING	2,000	63,752				9.00
10.00	01000	DIETARY	820	2,783	100			10.00
11.00	01100	CAFETERIA	0	925	0	1,865		11.00
13.00	01300	NURSING ADMINISTRATION	0	615	0	10	223,544	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,977	0	22	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,308	0	114	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,580	6,607	100	203	37,171	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,865	5,428	0	90	16,894	50.00
51.00	05100	RECOVERY ROOM	0	628	0	8	1,646	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,205	5,293	0	125	25,934	54.00
54.01	05401	ONCOLOGY	0	2,085	0	74	15,447	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	2,081	0	134	27,820	60.00
65.00	06500	RESPIRATORY THERAPY	240	131	0	18	3,844	65.00
66.00	06600	PHYSICAL THERAPY	561	3,737	0	51	11,328	66.00
67.00	06700	OCCUPATIONAL THERAPY	258	863	0	28	6,500	67.00
68.00	06800	SPEECH PATHOLOGY	11	181	0	12	1,146	68.00
69.00	06900	ELECTROCARDIOLOGY	0	402	0	31	6,415	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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	356	0	76	15,732	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	12,965	0	396	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	1,570	0	28	0	90.01
90.02	09002	ORTHOPAEDICS	0	1,078	0	6	0	90.02
90.03	09003	RHEUMATOLOGY	0	1,439	0	49	0	90.03
90.04	09004	ENDOCRINOLOGY	0	360	0	44	0	90.04
90.05	09005	PEDIATRICS	0	1,429	0	30	0	90.05
90.06	09006	WOMEN'S HEALTH	0	1,075	0	20	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	30	0	90.07
91.00	09100	EMERGENCY	2,955	3,858	0	200	41,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,728	0	58	11,965	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,495	62,902	100	1,857	223,544	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	850	0	8	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE	0	0	0	0	0	194.00
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)	121,603	876,989	404,480	378,848	45,017	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.267521	13.756259	4,044.800000	203.135657	0.201379	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,321	48,690	78,403	28,928	16,823	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.642955	0.763741	784.030000	15.510992	0.075256	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: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 4:59 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		
			14.00	16.00		
		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	1,401,873			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,447	94,400		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	64,936	40,560		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	363,515	0		50.00
51.00	05100	RECOVERY ROOM	1,273	8,920		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,069	10,800		54.00
54.01	05401	ONCOLOGY	13,192	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	542,795	0		60.00
65.00	06500	RESPIRATORY THERAPY	3,832	200		65.00
66.00	06600	PHYSICAL THERAPY	4,235	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	921	0		67.00
68.00	06800	SPEECH PATHOLOGY	697	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1,561	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	93,090	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	83,396	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,555	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	65,041	0		90.00
90.01	09001	SURGICAL ASSOCIATES	2,415	0		90.01
90.02	09002	ORTHOPAEDICS	594	0		90.02
90.03	09003	RHEUMATOLOGY	3,005	0		90.03
90.04	09004	ENDOCRINOLOGY	28,152	0		90.04
90.05	09005	PEDIATRICS	8,532	0		90.05
90.06	09006	WOMEN'S HEALTH	2,578	0		90.06
90.07	09007	PAIN MANAGEMENT	2,822	0		90.07
91.00	09100	EMERGENCY	44,070	33,920		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	14,150	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,401,873	94,400		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	FOUNDATION	0	0		193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0		193.02
194.00	07950	OTHER NON REIMBURSABLE	0	0		194.00
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)	351,455	716,232		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.250704	7.587203		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	56,365	44,484		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.040207	0.471229		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
						Costs		
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,951,278		2,951,278	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,364,047		1,364,047	0	0	50.00
51.00	05100	RECOVERY ROOM	161,270		161,270	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,938,132		1,938,132	0	0	54.00
54.01	05401	ONCOLOGY	721,232		721,232	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
60.00	06000	LABORATORY	2,362,636		2,362,636	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	177,405	0	177,405	0	0	65.00
66.00	06600	PHYSICAL THERAPY	770,531	0	770,531	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	438,538	0	438,538	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	109,172	0	109,172	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	232,994		232,994	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	491,368		491,368	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	123,303		123,303	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,650,712		5,650,712	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,660,781		2,660,781	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	234,179		234,179	0	0	90.01
90.02	09002	ORTHOPAEDICS	119,936		119,936	0	0	90.02
90.03	09003	RHEUMATOLOGY	286,405		286,405	0	0	90.03
90.04	09004	ENDOCRINOLOGY	228,103		228,103	0	0	90.04
90.05	09005	PEDIATRICS	306,138		306,138	0	0	90.05
90.06	09006	WOMEN'S HEALTH	151,689		151,689	0	0	90.06
90.07	09007	PAIN MANAGEMENT	160,687		160,687	0	0	90.07
91.00	09100	EMERGENCY	3,365,860		3,365,860	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,000,512		1,000,512		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	945,626		945,626	0	0	95.00
200.00		Subtotal (see instructions)	26,952,534	0	26,952,534	0	0	200.00
201.00		Less Observation Beds	1,000,512		1,000,512		0	201.00
202.00		Total (see instructions)	25,952,022	0	25,952,022	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,242,241		3,242,241			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	110,553	2,862,495	2,973,048	0.458804	0.000000	50.00
51.00	05100	RECOVERY ROOM	17,628	803,674	821,302	0.196359	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	692,314	20,249,561	20,941,875	0.092548	0.000000	54.00
54.01	05401	ONCOLOGY	0	546,546	546,546	1.319618	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00	06000	LABORATORY	685,139	9,783,802	10,468,941	0.225681	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	113,111	197,049	310,160	0.571979	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	176,537	2,120,171	2,296,708	0.335494	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,989	1,672,630	1,800,619	0.243548	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	57,363	187,519	244,882	0.445815	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	262,020	2,378,707	2,640,727	0.088231	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	150,737	3,688,378	3,839,115	0.127990	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	572,508	572,508	0.215373	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	886,123	10,682,608	11,568,731	0.488447	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20,080	822,148	842,228	3.159217	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	31,295	31,295	7.482953	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	20,664	20,664	5.804104	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	129,368	129,368	2.213878	0.000000	90.03
90.04	09004	ENDOCRINOLOGY	0	47,599	47,599	4.792181	0.000000	90.04
90.05	09005	PEDIATRICS	0	165,727	165,727	1.847243	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	39,387	39,387	3.851245	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	103,807	103,807	1.547940	0.000000	90.07
91.00	09100	EMERGENCY	10,646	6,058,962	6,069,608	0.554543	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,934	1,055,369	1,060,303	0.943610	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	863,457	863,457	1.095163	0.000000	95.00
200.00		Subtotal (see instructions)	6,557,415	65,083,431	71,640,846			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,557,415	65,083,431	71,640,846			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ONCOLOGY	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
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
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0.000000	90.03
90.04	09004	ENDOCRINOLOGY	0.000000	90.04
90.05	09005	PEDIATRICS	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	90.07
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/24/2019 4:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,951,278		2,951,278	0	2,951,278	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,364,047		1,364,047	0	1,364,047	50.00
51.00	05100	RECOVERY ROOM	161,270		161,270	0	161,270	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,938,132		1,938,132	0	1,938,132	54.00
54.01	05401	ONCOLOGY	721,232		721,232	0	721,232	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
60.00	06000	LABORATORY	2,362,636		2,362,636	0	2,362,636	60.00
65.00	06500	RESPIRATORY THERAPY	177,405	0	177,405	0	177,405	65.00
66.00	06600	PHYSICAL THERAPY	770,531	0	770,531	0	770,531	66.00
67.00	06700	OCCUPATIONAL THERAPY	438,538	0	438,538	0	438,538	67.00
68.00	06800	SPEECH PATHOLOGY	109,172	0	109,172	0	109,172	68.00
69.00	06900	ELECTROCARDIOLOGY	232,994		232,994	0	232,994	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	491,368		491,368	0	491,368	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	123,303		123,303	0	123,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,650,712		5,650,712	0	5,650,712	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,660,781		2,660,781	0	2,660,781	90.00
90.01	09001	SURGICAL ASSOCIATES	234,179		234,179	0	234,179	90.01
90.02	09002	ORTHOPAEDICS	119,936		119,936	0	119,936	90.02
90.03	09003	RHEUMATOLOGY	286,405		286,405	0	286,405	90.03
90.04	09004	ENDOCRINOLOGY	228,103		228,103	0	228,103	90.04
90.05	09005	PEDIATRICS	306,138		306,138	0	306,138	90.05
90.06	09006	WOMEN'S HEALTH	151,689		151,689	0	151,689	90.06
90.07	09007	PAIN MANAGEMENT	160,687		160,687	0	160,687	90.07
91.00	09100	EMERGENCY	3,365,860		3,365,860	0	3,365,860	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,000,512		1,000,512		1,000,512	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	945,626		945,626	0	945,626	95.00
200.00		Subtotal (see instructions)	26,952,534	0	26,952,534	0	26,952,534	200.00
201.00		Less Observation Beds	1,000,512		1,000,512		1,000,512	201.00
202.00		Total (see instructions)	25,952,022	0	25,952,022	0	25,952,022	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/24/2019 4:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,242,241		3,242,241			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	110,553	2,862,495	2,973,048	0.458804	0.000000	50.00
51.00	05100	RECOVERY ROOM	17,628	803,674	821,302	0.196359	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	692,314	20,249,561	20,941,875	0.092548	0.000000	54.00
54.01	05401	ONCOLOGY	0	546,546	546,546	1.319618	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00	06000	LABORATORY	685,139	9,783,802	10,468,941	0.225681	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	113,111	197,049	310,160	0.571979	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	176,537	2,120,171	2,296,708	0.335494	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,989	1,672,630	1,800,619	0.243548	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	57,363	187,519	244,882	0.445815	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	262,020	2,378,707	2,640,727	0.088231	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	150,737	3,688,378	3,839,115	0.127990	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	572,508	572,508	0.215373	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	886,123	10,682,608	11,568,731	0.488447	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20,080	822,148	842,228	3.159217	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	31,295	31,295	7.482953	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	20,664	20,664	5.804104	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	129,368	129,368	2.213878	0.000000	90.03
90.04	09004	ENDOCRINOLOGY	0	47,599	47,599	4.792181	0.000000	90.04
90.05	09005	PEDIATRICS	0	165,727	165,727	1.847243	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	39,387	39,387	3.851245	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	103,807	103,807	1.547940	0.000000	90.07
91.00	09100	EMERGENCY	10,646	6,058,962	6,069,608	0.554543	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,934	1,055,369	1,060,303	0.943610	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	863,457	863,457	1.095163	0.000000	95.00
200.00		Subtotal (see instructions)	6,557,415	65,083,431	71,640,846			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,557,415	65,083,431	71,640,846			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/24/2019 4:59 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ONCOLOGY	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
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
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0.000000	90.03
90.04	09004	ENDOCRINOLOGY	0.000000	90.04
90.05	09005	PEDIATRICS	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	90.07
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II | Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	176,240	2,973,048	0.059279	56,770	3,365	50.00
51.00	05100	RECOVERY ROOM	22,093	821,302	0.026900	11,164	300	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	172,108	20,941,875	0.008218	436,951	3,591	54.00
54.01	05401	ONCOLOGY	65,970	546,546	0.120703	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
60.00	06000	LABORATORY	106,380	10,468,941	0.010161	442,777	4,499	60.00
65.00	06500	RESPIRATORY THERAPY	6,439	310,160	0.020760	78,057	1,620	65.00
66.00	06600	PHYSICAL THERAPY	109,383	2,296,708	0.047626	107,764	5,132	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,972	1,800,619	0.016090	74,689	1,202	67.00
68.00	06800	SPEECH PATHOLOGY	6,332	244,882	0.025857	31,095	804	68.00
69.00	06900	ELECTROCARDIOLOGY	14,294	2,640,727	0.005413	185,381	1,003	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,080	3,839,115	0.002365	27,996	66	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,521	572,508	0.007897	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,288	11,568,731	0.006681	502,044	3,354	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	382,161	842,228	0.453750	172	78	90.00
90.01	09001	SURGICAL ASSOCIATES	44,494	31,295	1.421761	0	0	90.01
90.02	09002	ORTHOPAEDICS	29,837	20,664	1.443912	0	0	90.02
90.03	09003	RHEUMATOLOGY	42,407	129,368	0.327801	0	0	90.03
90.04	09004	ENDOCRINOLOGY	13,879	47,599	0.291582	0	0	90.04
90.05	09005	PEDIATRICS	42,106	165,727	0.254068	0	0	90.05
90.06	09006	WOMEN'S HEALTH	30,633	39,387	0.777744	0	0	90.06
90.07	09007	PAIN MANAGEMENT	2,800	103,807	0.026973	0	0	90.07
91.00	09100	EMERGENCY	162,863	6,069,608	0.026833	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	107,363	1,060,303	0.101257	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,657,643	67,535,148		1,954,860	25,014	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1304

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

Worksheet D Part IV

Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ONCOLOGY	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	0	0	90.03
90.04	09004	ENDOCRINOLOGY	0	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	0	0	90.07
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1304

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

Worksheet D Part IV

Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,973,048	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	821,302	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,941,875	0.000000	54.00
54.01	05401	ONCOLOGY	0	0	0	546,546	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	10,468,941	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	310,160	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,296,708	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,800,619	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	244,882	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,640,727	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,839,115	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	572,508	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,568,731	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	842,228	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	31,295	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	20,664	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	129,368	0.000000	90.03
90.04	09004	ENDOCRINOLOGY	0	0	0	47,599	0.000000	90.04
90.05	09005	PEDIATRICS	0	0	0	165,727	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	39,387	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	103,807	0.000000	90.07
91.00	09100	EMERGENCY	0	0	0	6,069,608	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,060,303	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	67,535,148		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	56,770	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	11,164	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	436,951	0	0	0	54.00
54.01	05401	ONCOLOGY	0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	442,777	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	78,057	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	107,764	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	74,689	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	31,095	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	185,381	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	27,996	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	0.000000	502,044	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	172	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0.000000	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0.000000	0	0	0	0	90.03
90.04	09004	ENDOCRINOLOGY	0.000000	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0.000000	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	0	0	0	0	90.07
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,954,860	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.458804	0	1,686,622	0	0	50.00
51.00	05100	RECOVERY ROOM	0.196359	0	260,389	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092548	0	6,458,635	0	0	54.00
54.01	05401	ONCOLOGY	1.319618	0	370,951	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.225681	0	3,464,694	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.571979	0	77,166	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.335494	0	827,642	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.243548	0	585,697	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.445815	0	32,953	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.088231	0	967,531	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.127990	0	86,881	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.215373	0	203,282	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488447	0	6,284,415	47,258	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3.159217	0	246,705	16,814	0	90.00
90.01	09001	SURGICAL ASSOCIATES	7.482953	0	15,502	0	0	90.01
90.02	09002	ORTHOPAEDICS	5.804104	0	10,890	0	0	90.02
90.03	09003	RHEUMATOLOGY	2.213878	0	59,408	0	0	90.03
90.04	09004	ENDOCRINOLOGY	4.792181	0	26,638	0	0	90.04
90.05	09005	PEDIATRICS	1.847243	0	103	0	0	90.05
90.06	09006	WOMEN'S HEALTH	3.851245	0	4,254	0	0	90.06
90.07	09007	PAIN MANAGEMENT	1.547940	0	23,800	0	0	90.07
91.00	09100	EMERGENCY	0.554543	0	1,344,010	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.943610	0	559,253	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.095163		0			95.00
200.00		Subtotal (see instructions)		0	23,597,421	64,072	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	23,597,421	64,072	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	773,829	0	50.00
51.00	05100	RECOVERY ROOM	51,130	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	597,734	0	54.00
54.01	05401	ONCOLOGY	489,514	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	781,916	0	60.00
65.00	06500	RESPIRATORY THERAPY	44,137	0	65.00
66.00	06600	PHYSICAL THERAPY	277,669	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	142,645	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,691	0	68.00
69.00	06900	ELECTROCARDIOLOGY	85,366	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,120	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	43,781	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,069,604	23,083	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	779,395	53,119	90.00
90.01	09001	SURGICAL ASSOCIATES	116,001	0	90.01
90.02	09002	ORTHOPAEDICS	63,207	0	90.02
90.03	09003	RHEUMATOLOGY	131,522	0	90.03
90.04	09004	ENDOCRINOLOGY	127,654	0	90.04
90.05	09005	PEDIATRICS	190	0	90.05
90.06	09006	WOMEN'S HEALTH	16,383	0	90.06
90.07	09007	PAIN MANAGEMENT	36,841	0	90.07
91.00	09100	EMERGENCY	745,311	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	527,717	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	8,927,357	76,202	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	8,927,357	76,202	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1304
Component CCN: 15-Z304

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

Worksheet D Part V
Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.458804	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.196359	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092548	0	0	0	0	54.00
54.01	05401	ONCOLOGY	1.319618	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.225681	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.571979	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.335494	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.243548	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.445815	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.088231	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.127990	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.215373	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488447	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3.159217	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	7.482953	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	5.804104	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	2.213878	0	0	0	0	90.03
90.04	09004	ENDOCRINOLOGY	4.792181	0	0	0	0	90.04
90.05	09005	PEDIATRICS	1.847243	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	3.851245	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	1.547940	0	0	0	0	90.07
91.00	09100	EMERGENCY	0.554543	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.943610	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.095163		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ONCOLOGY	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
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	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	90.01
90.02	09002	ORTHOPAEDICS	0	0	90.02
90.03	09003	RHEUMATOLOGY	0	0	90.03
90.04	09004	ENDOCRINOLOGY	0	0	90.04
90.05	09005	PEDIATRICS	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	90.07
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,024	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,949	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)	1,268	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	58	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	17	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)	870	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)	58	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.02	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.02	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,951,278	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)	2,635	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)	87,847	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,863,431	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,863,431	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)	1,469.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,278,187	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,278,187	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	547,161	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,825,348	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)	85,212	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)	85,212	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)	681	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,469.18	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,000,512	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	316,695	2,951,278	0.107308	1,000,512	107,363	90.00
91.00	Nursing School cost	0	2,951,278	0.000000	1,000,512	0	91.00
92.00	Allied health cost	0	2,951,278	0.000000	1,000,512	0	92.00
93.00	All other Medical Education	0	2,951,278	0.000000	1,000,512	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 4:59 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)	2,024	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,949	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)	1,268	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	58	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	17	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)	114	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,951,278	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)	85,288	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,865,990	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,865,990	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)	1,470.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	167,636	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)	167,636	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1304	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/24/2019 4:59 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)						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)	156,299	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	323,935	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)	681	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,470.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,001,404	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 Date/Time Prepared: 5/24/2019 4:59 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	316,695	2,951,278	0.107308	1,001,404	107,459	90.00
91.00	Nursing School cost	0	2,951,278	0.000000	1,001,404	0	91.00
92.00	Allied health cost	0	2,951,278	0.000000	1,001,404	0	92.00
93.00	All other Medical Education	0	2,951,278	0.000000	1,001,404	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,330,803		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.458804	56,770	26,046	50.00
51.00	05100	RECOVERY ROOM	0.196359	11,164	2,192	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092548	436,951	40,439	54.00
54.01	05401	ONCOLOGY	1.319618	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.225681	442,777	99,926	60.00
65.00	06500	RESPIRATORY THERAPY	0.571979	78,057	44,647	65.00
66.00	06600	PHYSICAL THERAPY	0.335494	107,764	36,154	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.243548	74,689	18,190	67.00
68.00	06800	SPEECH PATHOLOGY	0.445815	31,095	13,863	68.00
69.00	06900	ELECTROCARDIOLOGY	0.088231	185,381	16,356	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.127990	27,996	3,583	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.215373	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488447	502,044	245,222	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.159217	172	543	90.00
90.01	09001	SURGICAL ASSOCIATES	7.482953	0	0	90.01
90.02	09002	ORTHOPAEDICS	5.804104	0	0	90.02
90.03	09003	RHEUMATOLOGY	2.213878	0	0	90.03
90.04	09004	ENDOCRINOLOGY	4.792181	0	0	90.04
90.05	09005	PEDIATRICS	1.847243	0	0	90.05
90.06	09006	WOMEN'S HEALTH	3.851245	0	0	90.06
90.07	09007	PAIN MANAGEMENT	1.547940	0	0	90.07
91.00	09100	EMERGENCY	0.554543	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.943610	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)		1,954,860	547,161	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,954,860		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.458804	0	0	50.00
51.00	05100	RECOVERY ROOM	0.196359	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092548	7,880	729	54.00
54.01	05401	ONCOLOGY	1.319618	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.225681	9,796	2,211	60.00
65.00	06500	RESPIRATORY THERAPY	0.571979	5,460	3,123	65.00
66.00	06600	PHYSICAL THERAPY	0.335494	13,396	4,494	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.243548	12,979	3,161	67.00
68.00	06800	SPEECH PATHOLOGY	0.445815	3,333	1,486	68.00
69.00	06900	ELECTROCARDIOLOGY	0.088231	1,082	95	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.127990	1,255	161	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.215373	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488447	28,955	14,143	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.159217	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	7.482953	0	0	90.01
90.02	09002	ORTHOPAEDICS	5.804104	0	0	90.02
90.03	09003	RHEUMATOLOGY	2.213878	0	0	90.03
90.04	09004	ENDOCRINOLOGY	4.792181	0	0	90.04
90.05	09005	PEDIATRICS	1.847243	0	0	90.05
90.06	09006	WOMEN'S HEALTH	3.851245	0	0	90.06
90.07	09007	PAIN MANAGEMENT	1.547940	0	0	90.07
91.00	09100	EMERGENCY	0.554543	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.943610	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)		84,136	29,603	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)		84,136		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/24/2019 4:59 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		184,588		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.458804	44,593	20,459	50.00
51.00	05100	RECOVERY ROOM	0.196359	6,464	1,269	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092548	43,671	4,042	54.00
54.01	05401	ONCOLOGY	1.319618	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.225681	61,535	13,887	60.00
65.00	06500	RESPIRATORY THERAPY	0.571979	7,161	4,096	65.00
66.00	06600	PHYSICAL THERAPY	0.335494	13,706	4,598	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.243548	6,228	1,517	67.00
68.00	06800	SPEECH PATHOLOGY	0.445815	3,437	1,532	68.00
69.00	06900	ELECTROCARDIOLOGY	0.088231	3,457	305	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.127990	28,922	3,702	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.215373	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488447	108,581	53,036	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.159217	14,945	47,214	90.00
90.01	09001	SURGICAL ASSOCIATES	7.482953	0	0	90.01
90.02	09002	ORTHOPAEDICS	5.804104	0	0	90.02
90.03	09003	RHEUMATOLOGY	2.213878	0	0	90.03
90.04	09004	ENDOCRINOLOGY	4.792181	0	0	90.04
90.05	09005	PEDIATRICS	1.847243	0	0	90.05
90.06	09006	WOMEN'S HEALTH	3.851245	0	0	90.06
90.07	09007	PAIN MANAGEMENT	1.547940	0	0	90.07
91.00	09100	EMERGENCY	0.554543	1,157	642	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.943610	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)		343,857	156,299	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)		343,857		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1304	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/24/2019 4:59 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,003,559	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,003,559	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	9,093,595	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	70,196	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,984,487	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)	5,038,912	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)	5,038,912	30.00
31.00	Primary payer payments	5,022	31.00
32.00	Subtotal (line 30 minus line 31)	5,033,890	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)	241,307	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	156,850	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	162,562	36.00
37.00	Subtotal (see instructions)	5,190,740	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,190,740	40.00
40.01	Sequestration adjustment (see instructions)	103,815	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	4,646,644	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	440,281	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: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,033,737		4,646,644	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	09/14/2018	214,300		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)		214,300		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)		1,248,037		4,646,644	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		274,228		440,281	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,522,265		5,086,925	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: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		73,349		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)		73,349		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		40,295		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		113,644		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: 15-1304	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/24/2019 4:59 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1304 Component CCN: 15-Z304	Period: From 01/01/2018 To 12/31/2018	Worksheet E-2 Date/Time Prepared: 5/24/2019 4:59 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	86,064	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	29,899	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	58	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	115,963	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	115,963	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	115,963	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	115,963	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	115,963	0	19.00
19.01	Sequestration adjustment (see instructions)	2,319	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	73,349	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	40,295	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-3 Part V Date/Time Prepared: 5/24/2019 4:59 pm

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,825,348	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,825,348	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,843,601	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,843,601	19.00
20.00	Deductibles (exclude professional component)	300,136	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,543,465	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,543,465	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	15,180	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	9,867	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,553,332	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,553,332	30.00
30.01	Sequestration adjustment (see instructions)	31,067	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,248,037	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	274,228	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-3 Part VII Date/Time Prepared: 5/24/2019 4:59 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	323,935		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)	323,935	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)	323,935	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	184,588		8.00
9.00	Ancillary service charges	343,857	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)	528,445	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)	528,445	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	204,510	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)	323,935	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)	323,935	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)	323,935	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)	323,935	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	323,935	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)	323,935	0	40.00
41.00	Interim payments	117,273	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	206,662	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: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/24/2019 4:59 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	2,232,830	0	0	0	1.00
2.00	Temporary investments	1,999,687	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	17,683,089	0	0	0	4.00
5.00	Other receivable	490,885	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,998,085	0	0	0	6.00
7.00	Inventory	1,059,632	0	0	0	7.00
8.00	Prepaid expenses	472,346	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,940,384	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	37,292,857	0	0	0	15.00
16.00	Accumulated depreciation	-21,844,657	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	15,448,200	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	28,388,584	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,335,028	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,032,523	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	8,279,052	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,646,603	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	4,289,792	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,289,792	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,936,395	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	12,452,189				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)	12,452,189	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	28,388,584	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/24/2019 4:59 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		13,571,382		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,119,193				2.00
3.00	Total (sum of line 1 and line 2)		12,452,189		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)		12,452,189		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)		12,452,189		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: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/24/2019 4:59 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,242,241		3,242,241	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,242,241		3,242,241	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,242,241		3,242,241	17.00
18.00	Ancillary services	3,279,514	55,745,647	59,025,161	18.00
19.00	Outpatient services	35,661	8,474,325	8,509,986	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	863,457	863,457	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	407,499	8,676,103	9,083,602	27.00
27.01	PRIOR PERIOD OBSERVATION REVENUE	0	-141,030	-141,030	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,964,915	73,618,502	80,583,417	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,868,158		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)		34,868,158		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/24/2019 4:59 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	80,583,417	1.00
2.00	Less contractual allowances and discounts on patients' accounts	48,580,053	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,003,364	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	34,868,158	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,864,794	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING EXPENSES/INCOME	926,498	24.00
24.01	NON-OPERATING EXPENSES/INCOME	377,097	24.01
24.02	CONTRACT PHARMACY	442,006	24.02
25.00	Total other income (sum of lines 6-24)	1,745,601	25.00
26.00	Total (line 5 plus line 25)	-1,119,193	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,119,193	29.00