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: 15-1309	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/27/2018 3:56 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/27/2018 Time: 3:56 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 ST. VINCENT CLAY HOSPITAL (15-1309) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 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	86,211	247,076	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	76,053	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	162,264	247,076	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 10:22 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1206 EAST NATIONAL AVENUE	PO Box:			1.00
2.00	City: BRAZIL	State: IN	Zip Code: 47834	County: CLAY	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	ST. VINCENT CLAY HOSPITAL	151309	45460	1	08/08/2001	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	ST. VINCENT CLAY SWING BEDS	15Z309	45460		08/08/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 10:22 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		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) or (ii)? 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) or (ii)? 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

		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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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

	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 10:22 am

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

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

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

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

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		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.		Y	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.	N	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.	N	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.	N	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.	N	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.	N	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.	Y	Y	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 10:22 am

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	53,683	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.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046	140.00

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		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: ST. VINCENT HEALTH		Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 250 WEST 96TH STREET SUITE 215		PO Box:		142.00
143.00	City: INDIANAPOLIS		State: IN	Zip Code: 46260	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.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	Y	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/26/2018 10:22 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			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	10/16/2018	Y	10/16/2018
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 11/26/2018 10:22 am

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

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3519	JILL.HILL1@ASCENSION.ORG	43.00

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		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.	REIMBURSEMENT 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: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 11/26/2018 10:22 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	18,312.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	18,312.00	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	18,312.00	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: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2018 10:22 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	453	2	762			1.00
2.00	HMO and other (see instructions)	99	99				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	444	0	485			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	897	2	1,247			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)	897	2	1,247	0.00	65.13	14.00
15.00	CAH visits	11,969	465	35,831			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	0	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	65.13	27.00
28.00	Observation Bed Days		0	380			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			1			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: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 11/26/2018 10:22 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	127	2	226	1.00
2.00	HMO and other (see instructions)			26	29		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	127	2	226	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: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/26/2018 10:22 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.294667	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	257,627	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	15,502,373	6.00
7.00	Medicaid cost (line 1 times line 6)	4,568,038	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)	4,310,411	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,310,411	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,476,613	1,011,172	4,487,785	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,024,443	1,011,172	2,035,615	21.00
22.00	Payments received from patients for amounts previously written off as charity care	99,567	36,737	136,304	22.00
23.00	Cost of charity care (line 21 minus line 22)	924,876	974,435	1,899,311	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	744,605	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	483,994	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	744,605	27.01
28.00	Non-Medicare bad debt expense (see instructions)	0	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	260,611	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,159,922	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,470,333	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/26/2018 10:22 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		548,235	548,235	-157,309	390,926	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		635,328	635,328	153,939	789,267	2.00
2.01	00201	CAP REL COSTS-MOB		212,679	212,679	0	212,679	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	178,611	1,736,591	1,915,202	0	1,915,202	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	963,886	4,354,221	5,318,107	-10,130	5,307,977	5.00
7.00	00700	OPERATION OF PLANT	39	429,847	429,886	0	429,886	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	43,470	43,470	0	43,470	8.00
9.00	00900	HOUSEKEEPING	0	332,353	332,353	0	332,353	9.00
10.00	01000	DIETARY	0	399,383	399,383	-271,307	128,076	10.00
11.00	01100	CAFETERIA	0	0	0	271,307	271,307	11.00
13.00	01300	NURSING ADMINISTRATION	165,457	29,987	195,444	0	195,444	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	58	23,830	23,888	0	23,888	14.00
15.00	01500	PHARMACY	16,474	755,456	771,930	0	771,930	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	346	346	0	346	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	828,730	38,613	867,343	-1,133	866,210	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	370,131	323,390	693,521	-63,385	630,136	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	640,721	691,654	1,332,375	-1,149	1,331,226	54.00
60.00	06000	LABORATORY	20,919	1,021,639	1,042,558	0	1,042,558	60.00
65.00	06500	RESPIRATORY THERAPY	173,988	8,822	182,810	0	182,810	65.00
66.00	06600	PHYSICAL THERAPY	0	708,725	708,725	-166,545	542,180	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	166,474	166,474	67.00
68.00	06800	SPEECH PATHOLOGY	0	84,062	84,062	0	84,062	68.00
69.00	06900	ELECTROCARDIOLOGY	119,977	79,808	199,785	0	199,785	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,039	3,039	76,868	79,907	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	117,620	117,620	0	117,620	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	844,318	1,369,074	2,213,392	-11,130	2,202,262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,323,309	13,948,172	18,271,481	-13,500	18,257,981	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-13,372	-13,372	13,500	128	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	732	732	0	732	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
200.00		TOTAL (SUM OF LINES 118 through 199)	4,323,309	13,935,532	18,258,841	0	18,258,841	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/26/2018 10:22 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-124,670	266,256		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-144,475	644,792		2.00
2.01	00201	CAP REL COSTS-MOB	0	212,679		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	286,806	2,202,008		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	34,122	5,342,099		5.00
7.00	00700	OPERATION OF PLANT	0	429,886		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	43,470		8.00
9.00	00900	HOUSEKEEPING	0	332,353		9.00
10.00	01000	DIETARY	0	128,076		10.00
11.00	01100	CAFETERIA	-34,280	237,027		11.00
13.00	01300	NURSING ADMINISTRATION	0	195,444		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,888		14.00
15.00	01500	PHARMACY	60	771,990		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-346	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	866,210		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	630,136		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-36,887	1,294,339		54.00
60.00	06000	LABORATORY	0	1,042,558		60.00
65.00	06500	RESPIRATORY THERAPY	0	182,810		65.00
66.00	06600	PHYSICAL THERAPY	-554	541,626		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	166,474		67.00
68.00	06800	SPEECH PATHOLOGY	0	84,062		68.00
69.00	06900	ELECTROCARDIOLOGY	0	199,785		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	79,907		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	117,620		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-150,000	2,052,262		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-170,224	18,087,757		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	128		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0		193.01
193.02	19302	PUBLIC RELATIONS	0	0		193.02
193.03	19303	FOUNDATION	0	0		193.03
193.04	19304	MISSION SERVICES	0	732		193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0		193.05
193.06	19306	ENTERTAINMENT	0	0		193.06
193.07	19307	MARKETING	0	0		193.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-170,224	18,088,617		200.00

RECLASSIFICATIONS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 10:22 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	B - INTEREST				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,370	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	144,475	2.00
	TOTALS		0	147,845	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	0	271,307	1.00
	TOTALS		0	271,307	
	D - PROPERTY INSURANCE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,464	1.00
	TOTALS		0	9,464	
	E - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	76,868	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
	TOTALS		0	76,868	
	F - OT RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	0	166,474	1.00
	TOTALS		0	166,474	
	G - PHYSICIAN PRIVATE OFFICE RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	13,500	1.00
	TOTALS		0	13,500	
500.00	Grand Total: Increases		0	685,458	500.00

RECLASSIFICATIONS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 10:22 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,370	11		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	144,475	11		2.00
	TOTALS		0	147,845			
	C - CAFETERIA						
1.00	DIETARY	10.00	0	271,307	0		1.00
	TOTALS		0	271,307			
	D - PROPERTY INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,464	11		1.00
	TOTALS		0	9,464			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	1,133	0		1.00
2.00	OPERATING ROOM	50.00	0	63,385	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,149	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	71	0		4.00
5.00	EMERGENCY	91.00	0	11,130	0		5.00
	TOTALS		0	76,868			
	F - OT RECLASS						
1.00	PHYSICAL THERAPY	66.00	0	166,474	0		1.00
	TOTALS		0	166,474			
	G - PHYSICIAN PRIVATE OFFICE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	13,500	0		1.00
	TOTALS		0	13,500			
500.00	Grand Total: Decreases		0	685,458			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/26/2018 10:22 am

		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	2,500	0	0	0	0	1.00
2.00	Land Improvements	192,578	0	0	0	0	2.00
3.00	Buildings and Fixtures	9,334,448	602,434	0	602,434	0	3.00
4.00	Building Improvements	995,040	0	0	0	0	4.00
5.00	Fixed Equipment	2,979,232	78,260	0	78,260	0	5.00
6.00	Movable Equipment	7,169,759	243,586	0	243,586	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,673,557	924,280	0	924,280	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	20,673,557	924,280	0	924,280	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,500	0	1.00
2.00	Land Improvements	192,578	0	2.00
3.00	Buildings and Fixtures	9,936,882	0	3.00
4.00	Building Improvements	995,040	0	4.00
5.00	Fixed Equipment	3,057,492	0	5.00
6.00	Movable Equipment	7,413,345	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	21,597,837	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	21,597,837	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II Date/Time Prepared: 11/26/2018 10:22 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	258,089	0	272,515	17,631	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	562,059	72,570	0	699	0	2.00
2.01	CAP REL COSTS-MOB	0	212,679	0	0	0	2.01
3.00	Total (sum of lines 1-2)	820,148	285,249	272,515	18,330	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	548,235		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	635,328		2.00
2.01	CAP REL COSTS-MOB	0	212,679		2.01
3.00	Total (sum of lines 1-2)	0	1,396,242		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/26/2018 10:22 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	11,127,000	0	11,127,000	0.515190	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,470,837	0	10,470,837	0.484810	0	2.00
2.01	CAP REL COSTS-MOB	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	21,597,837	0	21,597,837	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	133,419	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	417,584	72,570	2.00
2.01	CAP REL COSTS-MOB	0	0	0	0	212,679	2.01
3.00	Total (sum of lines 1-2)	0	0	0	551,003	285,249	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	115,206	17,631	0	0	266,256	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	153,939	699	0	0	644,792	2.00
2.01	CAP REL COSTS-MOB	0	0	0	0	212,679	2.01
3.00	Total (sum of lines 1-2)	269,145	18,330	0	0	1,123,727	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/26/2018 10:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-124,670	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-144,475	CAP REL COSTS-MVBLE EQUIP	2.00	9	2.00
2.01	Investment income - CAP REL COSTS-MOB (chapter 2)		0	CAP REL COSTS-MOB	2.01	0	2.01
3.00	Investment income - other (chapter 2)	B	-3,370	ADMINISTRATIVE & GENERAL	5.00	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	-207,420			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,351,027			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-34,280	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	60	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-346	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MOB		0	CAP REL COSTS-MOB	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/26/2018 10:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ACCRUED INCENTIVE	A	1,573	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	LATE PENALTY FEES	A	-17	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISC. INCOME - A&G	B	-17,873	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.04	ENTERTAINMENT	A	-3,927	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.08	LOBBYING	A	-312	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	DONATIONS	A	-6,444	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	MARKETING	A	-554	PHYSICAL THERAPY	66.00	0	33.10
33.12	PROVIDER TAX	B	-979,196	ADMINISTRATIVE & GENERAL	5.00	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-170,224				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/26/2018 10:22 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	285,233	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	4,440,179	3,455,381	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	80,996	0	3.00
3.01	193.05	OTHER NON-REIMBURSABLE	ASCENSION CHARGEBACK	154,453	154,453	3.01
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION CHARGEBACK	1,260	1,260	3.02
4.00	15.00	PHARMACY	ASCENSION CHARGEBACK	30,000	30,000	4.00
4.01	54.00	RADIOLOGY-DIAGNOSTIC	ASCENSION CHARGEBACK	35,285	35,285	4.01
4.02	69.00	ELECTROCARDIOLOGY	ASCENSION CHARGEBACK	34,875	34,875	4.02
4.03	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	272,515	272,515	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
4.06	0.00			0	0	4.06
4.07	0.00			0	0	4.07
4.08	0.00			0	0	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
4.11	0.00			0	0	4.11
4.12	0.00			0	0	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	0.00			0	0	4.18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
4.21	0.00			0	0	4.21
4.22	0.00			0	0	4.22
5.00	0		0	5,334,796	3,983,769	5.00

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

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

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

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

6.00	G	ST. VINCENT HEA	100.00	ST. VINCENT HEA	100.00	6.00
7.00	B	ST. VINCENT HOS	100.00	ST. VINCENT HOS	100.00	7.00
8.00	G	ASCENSION	100.00	ASCENSION	100.00	8.00
9.00	A	MEDXCEL	0.00	MEDXCEL	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/26/2018 10:22 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	285,233	0		1.00
2.00	984,798	0		2.00
3.00	80,996	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	11		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	9		4.16
4.17	0	9		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
5.00	1,351,027			5.00

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

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

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

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

6.00	ADMINISTRATION		6.00
7.00	HOSPITAL		7.00
8.00	ADMINISTRATION		8.00
9.00	TECHNOLOGY MGMT		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/26/2018 10:22 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,047,400	0	1,047,400	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	20,533	20,533	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	36,887	36,887	0	0	0	3.00
4.00	91.00	EMERGENCY	150,000	150,000	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,254,820	207,420	1,047,400		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	0		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	20,533		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	36,887		3.00
4.00	91.00	EMERGENCY	0	0	0	150,000		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	207,420		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2018 10:22 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					287	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)					11	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					9.57	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	1,759.00	3,259.00	4,814.00	2,934.00	0.00	9.00
10.00	AHSEA (see instructions)	94.15	81.87	53.21	25.00	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)	40.94	40.94	26.61			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)					165,610	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					266,814	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					256,153	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					688,577	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					73,350	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)					761,927	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)					761,927	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)					11,750	24.00
25.00	Assistants (line 4 times column 3, line 11)					293	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					12,043	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)					2,852	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					14,895	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)					14,895	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: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/26/2018 10:22 am

Physical Therapy | 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)	81.87	53.21	25.00	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)	761,927	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	14,895	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)	776,822	63.00
64.00	Total cost of outside supplier services (from your records)	529,873	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	12,043	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,852	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	14,895	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	2,852	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	2,852	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1309	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2018 10:22 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		245	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		6.40	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	2,312.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.61	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)	38.81	38.81	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)	179,434	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)	179,434	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)	179,434	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)	179,434	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)	9,508	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)	9,508	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)	1,568	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	11,076	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)	11,076	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/26/2018 10:22 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.61	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)	179,434	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	11,076	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)	190,510	63.00
64.00	Total cost of outside supplier services (from your records)	166,474	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	9,508	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,568	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	11,076	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	1,568	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	1,568	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2018 10:22 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					189	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					6.40	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	1,111.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	74.59	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)	37.30	37.30	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)					82,869	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)					82,869	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)					82,869	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)					82,869	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)					7,050	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)					7,050	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)					1,210	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					8,260	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)					8,260	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: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/26/2018 10:22 am

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)	74.59	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)	82,869		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	8,260		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)	91,129		63.00
64.00	Total cost of outside supplier services (from your records)	84,062		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	7,050		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,210		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	8,260		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	1,210		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	1,210		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: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 10:22 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP	MOB		
			0	1.00	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	266,256	266,256				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	644,792		644,792			2.00
2.01	00201	CAP REL COSTS-MOB	212,679		0	212,679		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,202,008	0	0	0	2,202,008	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,342,099	99,424	240,771	43,978	512,097	5.00
7.00	00700	OPERATION OF PLANT	429,886	54,641	132,323	0	21	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,470	5,711	13,830	0	0	8.00
9.00	00900	HOUSEKEEPING	332,353	3,167	7,670	0	0	9.00
10.00	01000	DIETARY	128,076	7,035	17,036	0	0	10.00
11.00	01100	CAFETERIA	237,027	3,990	9,663	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	195,444	6,234	15,097	0	87,904	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,888	0	0	0	31	14.00
15.00	01500	PHARMACY	771,990	3,125	7,568	0	8,752	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,706	67,096	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	866,210	17,985	43,555	0	440,290	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	630,136	7,383	17,880	0	196,644	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,294,339	5,120	12,400	14,729	340,404	54.00
60.00	06000	LABORATORY	1,042,558	4,187	10,140	0	11,114	60.00
65.00	06500	RESPIRATORY THERAPY	182,810	5,049	12,228	0	92,437	65.00
66.00	06600	PHYSICAL THERAPY	541,626	0	0	28,149	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	166,474	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	84,062	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	199,785	0	0	0	63,742	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,907	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	117,620	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,052,262	14,815	35,878	0	448,572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,087,757	265,572	643,135	86,856	2,202,008	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	684	1,657	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	128	0	0	125,823	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	732	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,088,617	266,256	644,792	212,679	2,202,008	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/26/2018 10:22 am

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,238,369	6,238,369				5.00
7.00	00700	OPERATION OF PLANT	616,871	324,742	941,613			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	63,011	33,171	41,788	137,970		8.00
9.00	00900	HOUSEKEEPING	343,190	180,667	23,174	616	547,647	9.00
10.00	01000	DIETARY	152,147	80,095	51,473	0	0	10.00
11.00	01100	CAFETERIA	250,680	131,966	29,197	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	304,679	160,393	45,615	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,919	12,592	0	0	0	14.00
15.00	01500	PHARMACY	791,435	416,638	22,866	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	94,802	49,907	202,730	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,368,040	720,183	131,600	31,426	156,470	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	852,043	448,544	54,024	17,097	104,314	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,666,992	877,561	78,922	23,612	52,157	54.00
60.00	06000	LABORATORY	1,067,999	562,231	30,638	0	26,078	60.00
65.00	06500	RESPIRATORY THERAPY	292,524	153,995	36,945	0	0	65.00
66.00	06600	PHYSICAL THERAPY	569,775	299,949	79,230	5,263	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	166,474	87,638	0	1,620	0	67.00
68.00	06800	SPEECH PATHOLOGY	84,062	44,253	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	263,527	138,730	0	4,270	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,907	42,066	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	117,620	61,919	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,551,527	1,343,207	108,403	49,701	156,471	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,959,593	6,170,447	936,605	133,605	495,490	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,341	1,232	5,008	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	125,951	66,305	0	4,365	52,157	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	732	385	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,088,617	6,238,369	941,613	137,970	547,647	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/26/2018 10:22 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
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	283,715					10.00
11.00	01100	CAFETERIA	0	411,843				11.00
13.00	01300	NURSING ADMINISTRATION	0	14,509	525,196			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	36,511		14.00
15.00	01500	PHARMACY	0	1,319	0	0	1,232,258	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	283,715	108,082	44,621	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	53,381	164,168	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	86,977	0	0	0	54.00
60.00	06000	LABORATORY	0	6,828	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	23,122	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	14,742	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	36,511	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,232,258	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	102,883	316,407	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	283,715	411,843	525,196	36,511	1,232,258	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
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)	283,715	411,843	525,196	36,511	1,232,258	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 10:22 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	347,439					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,614	2,858,751	0	2,858,751		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,638	1,737,209	0	1,737,209		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	112,260	2,898,481	0	2,898,481		54.00
60.00	06000	LABORATORY	58,369	1,752,143	0	1,752,143		60.00
65.00	06500	RESPIRATORY THERAPY	5,296	511,882	0	511,882		65.00
66.00	06600	PHYSICAL THERAPY	15,591	969,808	0	969,808		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,800	260,532	0	260,532		67.00
68.00	06800	SPEECH PATHOLOGY	1,289	129,604	0	129,604		68.00
69.00	06900	ELECTROCARDIOLOGY	13,046	434,315	0	434,315		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	158,484	0	158,484		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	179,539	0	179,539		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,232,258	0	1,232,258		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	78,536	4,707,135	0	4,707,135		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	347,439	17,830,141	0	17,830,141		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,581	0	8,581		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	248,778	0	248,778		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0		193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0		193.02
193.03	19303	FOUNDATION	0	0	0	0		193.03
193.04	19304	MISSION SERVICES	0	1,117	0	1,117		193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0		193.05
193.06	19306	ENTERTAINMENT	0	0	0	0		193.06
193.07	19307	MARKETING	0	0	0	0		193.07
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	347,439	18,088,617	0	18,088,617		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 10:22 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	CAPITAL RELATED COSTS MOB	Subtotal	
			0	1.00	2.00	2.01	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	285,233	99,424	240,771	43,978	669,406	5.00
7.00	00700	OPERATION OF PLANT	0	54,641	132,323	0	186,964	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,711	13,830	0	19,541	8.00
9.00	00900	HOUSEKEEPING	0	3,167	7,670	0	10,837	9.00
10.00	01000	DIETARY	0	7,035	17,036	0	24,071	10.00
11.00	01100	CAFETERIA	0	3,990	9,663	0	13,653	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,234	15,097	0	21,331	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	3,125	7,568	0	10,693	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,706	67,096	0	94,802	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	17,985	43,555	0	61,540	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,383	17,880	0	25,263	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,120	12,400	14,729	32,249	54.00
60.00	06000	LABORATORY	0	4,187	10,140	0	14,327	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,049	12,228	0	17,277	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	28,149	28,149	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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	14,815	35,878	0	50,693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	285,233	265,572	643,135	86,856	1,280,796	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	684	1,657	0	2,341	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	125,823	125,823	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
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)	285,233	266,256	644,792	212,679	1,408,960	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 10:22 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	669,406				5.00
7.00	00700	OPERATION OF PLANT	0	34,846	221,810			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,559	9,844	32,944		8.00
9.00	00900	HOUSEKEEPING	0	19,386	5,459	147	35,829	9.00
10.00	01000	DIETARY	0	8,595	12,125	0	0	10.00
11.00	01100	CAFETERIA	0	14,161	6,878	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	17,211	10,745	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,351	0	0	0	14.00
15.00	01500	PHARMACY	0	44,707	5,387	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,355	47,755	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	77,279	31,000	7,504	10,237	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	48,131	12,726	4,082	6,825	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	94,167	18,591	5,638	3,412	54.00
60.00	06000	LABORATORY	0	60,330	7,217	0	1,706	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,524	8,703	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	32,186	18,664	1,257	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,404	0	387	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,749	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	14,886	0	1,020	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,514	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,644	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	144,133	25,536	11,867	10,237	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	662,118	220,630	31,902	32,417	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	132	1,180	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,115	0	1,042	3,412	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	41	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
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)	0	669,406	221,810	32,944	35,829	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 10:22 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
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	44,791					10.00
11.00	01100	CAFETERIA	0	34,692				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,222	50,509			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,351		14.00
15.00	01500	PHARMACY	0	111	0	0	60,898	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	44,791	9,104	4,291	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,497	15,788	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,327	0	0	0	54.00
60.00	06000	LABORATORY	0	575	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,948	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	1,242	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	1,351	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	60,898	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	8,666	30,430	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,791	34,692	50,509	1,351	60,898	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
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)	44,791	34,692	50,509	1,351	60,898	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 10:22 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	147,912					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,223	251,969	0	251,969		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,581	135,893	0	135,893		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,773	209,157	0	209,157		54.00
60.00	06000	LABORATORY	24,853	109,008	0	109,008		60.00
65.00	06500	RESPIRATORY THERAPY	2,255	46,707	0	46,707		65.00
66.00	06600	PHYSICAL THERAPY	6,639	86,895	0	86,895		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,044	11,835	0	11,835		67.00
68.00	06800	SPEECH PATHOLOGY	549	5,298	0	5,298		68.00
69.00	06900	ELECTROCARDIOLOGY	5,555	22,703	0	22,703		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,865	0	5,865		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,644	0	6,644		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	60,898	0	60,898		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	33,440	315,002	0	315,002		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	147,912	1,267,874	0	1,267,874		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,653	0	3,653		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	137,392	0	137,392		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0		193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0		193.02
193.03	19303	FOUNDATION	0	0	0	0		193.03
193.04	19304	MISSION SERVICES	0	41	0	41		193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0		193.05
193.06	19306	ENTERTAINMENT	0	0	0	0		193.06
193.07	19307	MARKETING	0	0	0	0		193.07
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	147,912	1,408,960	0	1,408,960		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 10:22 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	MOB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	2.00	2.01	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	82,473					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		82,473				2.00
2.01	00201	CAP REL COSTS-MOB		0	25,341			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	4,144,698		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,796	30,796	5,240	963,886	-6,238,369	5.00
7.00	00700	OPERATION OF PLANT	16,925	16,925	0	39	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,769	1,769	0	0	0	8.00
9.00	00900	HOUSEKEEPING	981	981	0	0	0	9.00
10.00	01000	DIETARY	2,179	2,179	0	0	0	10.00
11.00	01100	CAFETERIA	1,236	1,236	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,931	1,931	0	165,457	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	58	0	14.00
15.00	01500	PHARMACY	968	968	0	16,474	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,582	8,582	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,571	5,571	0	828,730	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,287	2,287	0	370,131	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,586	1,586	1,755	640,721	0	54.00
60.00	06000	LABORATORY	1,297	1,297	0	20,919	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,564	1,564	0	173,988	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,354	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	119,977	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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,589	4,589	0	844,318	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,261	82,261	10,349	4,144,698	-6,238,369	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	212	212	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	14,992	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
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)	266,256	644,792	212,679	2,202,008		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.228402	7.818219	8.392684	0.531283		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 10:22 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,850,248					5.00
7.00	00700	OPERATION OF PLANT	616,871	39,861				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	63,011	1,769	88,891			8.00
9.00	00900	HOUSEKEEPING	343,190	981	397	10,920		9.00
10.00	01000	DIETARY	152,147	2,179	0	0	100	10.00
11.00	01100	CAFETERIA	250,680	1,236	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	304,679	1,931	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,919	0	0	0	0	14.00
15.00	01500	PHARMACY	791,435	968	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	94,802	8,582	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,368,040	5,571	20,247	3,120	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	852,043	2,287	11,015	2,080	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,666,992	3,341	15,213	1,040	0	54.00
60.00	06000	LABORATORY	1,067,999	1,297	0	520	0	60.00
65.00	06500	RESPIRATORY THERAPY	292,524	1,564	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	569,775	3,354	3,391	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	166,474	0	1,044	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	84,062	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	263,527	0	2,751	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,907	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	117,620	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,551,527	4,589	32,021	3,120	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,721,224	39,649	86,079	9,880	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,341	212	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	125,951	0	2,812	1,040	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	732	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
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)	6,238,369	941,613	137,970	547,647	283,715	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.526434	23.622413	1.552126	50.150824	2,837.150000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	669,406	221,810	32,944	35,829	44,791	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.056489	5.564587	0.370611	3.281044	447.910000	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: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 10:22 am

		Cost Center Description	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
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	5,308					11.00
13.00	01300	NURSING ADMINISTRATION	187	2,201				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	100			14.00
15.00	01500	PHARMACY	17	0	0	1,000		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	54,508,894	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,393	187	0	0	2,292,817	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	688	688	0	0	6,846,250	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,121	0	0	0	17,612,193	54.00
60.00	06000	LABORATORY	88	0	0	0	9,157,323	60.00
65.00	06500	RESPIRATORY THERAPY	298	0	0	0	830,909	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,446,072	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	753,042	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	202,257	68.00
69.00	06900	ELECTROCARDIOLOGY	190	0	0	0	2,046,800	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,326	1,326	0	0	12,321,231	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,308	2,201	100	1,000	54,508,894	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
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)	411,843	525,196	36,511	1,232,258	347,439	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	77.589111	238.616992	365.110000	1,232.258000	0.006374	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	34,692	50,509	1,351	60,898	147,912	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.535795	22.948205	13.510000	60.898000	0.002714	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: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,858,751		2,858,751	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,737,209		1,737,209	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,898,481		2,898,481	0	0	54.00
60.00	06000	LABORATORY	1,752,143		1,752,143	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	511,882	0	511,882	0	0	65.00
66.00	06600	PHYSICAL THERAPY	969,808	0	969,808	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	260,532	0	260,532	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	129,604	0	129,604	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	434,315		434,315	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	158,484		158,484	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	179,539		179,539	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,232,258		1,232,258	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,707,135		4,707,135	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	667,687		667,687		0	92.00
200.00		Subtotal (see instructions)	18,497,828	0	18,497,828	0	0	200.00
201.00		Less Observation Beds	667,687		667,687		0	201.00
202.00		Total (see instructions)	17,830,141	0	17,830,141	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,646,414		1,646,414			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	198,258	6,647,992	6,846,250	0.253746	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	368,074	17,244,120	17,612,194	0.164572	0.000000	54.00
60.00	06000	LABORATORY	573,712	8,583,611	9,157,323	0.191338	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	541,746	289,163	830,909	0.616051	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	204,642	2,241,430	2,446,072	0.396476	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	125,782	627,260	753,042	0.345973	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	13,250	189,006	202,256	0.640792	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	96,425	1,950,375	2,046,800	0.212192	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	223,995	919,379	1,143,374	0.138611	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,503	260,058	299,561	0.599340	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	608,550	3,949,043	4,557,593	0.270375	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	153,718	12,167,513	12,321,231	0.382034	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,712	641,691	646,403	1.032927	0.000000	92.00
200.00		Subtotal (see instructions)	4,798,781	55,710,641	60,509,422			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,798,781	55,710,641	60,509,422			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
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 PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
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: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 10:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,858,751		2,858,751	0	2,858,751	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,737,209		1,737,209	0	1,737,209	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,898,481		2,898,481	0	2,898,481	54.00
60.00	06000	LABORATORY	1,752,143		1,752,143	0	1,752,143	60.00
65.00	06500	RESPIRATORY THERAPY	511,882	0	511,882	0	511,882	65.00
66.00	06600	PHYSICAL THERAPY	969,808	0	969,808	0	969,808	66.00
67.00	06700	OCCUPATIONAL THERAPY	260,532	0	260,532	0	260,532	67.00
68.00	06800	SPEECH PATHOLOGY	129,604	0	129,604	0	129,604	68.00
69.00	06900	ELECTROCARDIOLOGY	434,315		434,315	0	434,315	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	158,484		158,484	0	158,484	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	179,539		179,539	0	179,539	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,232,258		1,232,258	0	1,232,258	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,707,135		4,707,135	0	4,707,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	667,687		667,687		667,687	92.00
200.00		Subtotal (see instructions)	18,497,828	0	18,497,828	0	18,497,828	200.00
201.00		Less Observation Beds	667,687		667,687		667,687	201.00
202.00		Total (see instructions)	17,830,141	0	17,830,141	0	17,830,141	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 10:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,646,414		1,646,414			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	198,258	6,647,992	6,846,250	0.253746	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	368,074	17,244,120	17,612,194	0.164572	0.000000	54.00
60.00	06000	LABORATORY	573,712	8,583,611	9,157,323	0.191338	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	541,746	289,163	830,909	0.616051	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	204,642	2,241,430	2,446,072	0.396476	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	125,782	627,260	753,042	0.345973	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	13,250	189,006	202,256	0.640792	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	96,425	1,950,375	2,046,800	0.212192	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	223,995	919,379	1,143,374	0.138611	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,503	260,058	299,561	0.599340	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	608,550	3,949,043	4,557,593	0.270375	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	153,718	12,167,513	12,321,231	0.382034	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,712	641,691	646,403	1.032927	0.000000	92.00
200.00		Subtotal (see instructions)	4,798,781	55,710,641	60,509,422			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,798,781	55,710,641	60,509,422			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 10:22 am

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
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
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 PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
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: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	135,893	6,846,250	0.019849	73,679	1,462	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	209,157	17,612,194	0.011876	118,555	1,408	54.00
60.00	06000	LABORATORY	109,008	9,157,323	0.011904	222,781	2,652	60.00
65.00	06500	RESPIRATORY THERAPY	46,707	830,909	0.056212	286,723	16,117	65.00
66.00	06600	PHYSICAL THERAPY	86,895	2,446,072	0.035524	31,947	1,135	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,835	753,042	0.015716	8,565	135	67.00
68.00	06800	SPEECH PATHOLOGY	5,298	202,256	0.026195	5,715	150	68.00
69.00	06900	ELECTROCARDIOLOGY	22,703	2,046,800	0.011092	40,741	452	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,865	1,143,374	0.005130	130,540	670	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,644	299,561	0.022179	20,125	446	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,898	4,557,593	0.013362	265,170	3,543	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	315,002	12,321,231	0.025566	2,257	58	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	58,850	646,403	0.091042	0	0	92.00
200.00		Total (lines 50 through 199)	1,074,755	58,863,008		1,206,798	28,228	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
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: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 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	6,846,250	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,612,194	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,157,323	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	830,909	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,446,072	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	753,042	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	202,256	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,046,800	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	1,143,374	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	299,561	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,557,593	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	12,321,231	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	646,403	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	58,863,008		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	73,679	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	118,555	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	222,781	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	286,723	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	31,947	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	8,565	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	5,715	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	40,741	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	130,540	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	20,125	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	265,170	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	2,257	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,206,798	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.253746	0	2,299,743	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164572	0	5,697,488	0	0	54.00
60.00	06000	LABORATORY	0.191338	0	3,108,515	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.616051	0	74,832	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.396476	0	734,072	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.345973	0	193,160	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.640792	0	15,719	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.212192	0	313,622	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.138611	0	314,274	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.599340	0	66,534	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270375	0	1,682,633	3,189	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.382034	0	2,865,605	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.032927	0	258,034	0	0	92.00
200.00		Subtotal (see instructions)		0	17,624,231	3,189	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	17,624,231	3,189	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	583,551	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	937,647	0		54.00
60.00	06000	LABORATORY	594,777	0		60.00
65.00	06500	RESPIRATORY THERAPY	46,100	0		65.00
66.00	06600	PHYSICAL THERAPY	291,042	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	66,828	0		67.00
68.00	06800	SPEECH PATHOLOGY	10,073	0		68.00
69.00	06900	ELECTROCARDIOLOGY	66,548	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,562	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,876	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	454,942	862		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,094,759	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	266,530	0		92.00
200.00		Subtotal (see instructions)	4,496,235	862		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,496,235	862		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.253746	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164572	0	0	0	0	54.00
60.00	06000	LABORATORY	0.191338	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.616051	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.396476	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.345973	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.640792	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.212192	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	0.138611	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.599340	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270375	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.382034	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.032927	0	0	0	0	92.00
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: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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 PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
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: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Hospital | Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,627	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,142	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)	762	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	242	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)	243	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	453	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)	235	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)	209	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,858,751	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)	852,179	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,006,572	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)	2,006,572	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)	1,757.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	795,953	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)	795,953	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	388,118	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,184,071	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)	412,911	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	367,228	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	780,139	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)	380	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,757.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	667,687	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	251,969	2,858,751	0.088140	667,687	58,850	90.00
91.00	Nursing School cost	0	2,858,751	0.000000	667,687	0	91.00
92.00	Allied health cost	0	2,858,751	0.000000	667,687	0	92.00
93.00	All other Medical Education	0	2,858,751	0.000000	667,687	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 10:22 am

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)	1,627	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,142	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)	762	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	242	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)	243	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2	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	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,858,751	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)	852,179	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,006,572	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)	2,006,572	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)	1,757.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,514	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,514	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 10:22 am

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)	147,297	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	150,811	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)	380	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,757.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	667,687	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 10:22 am

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	251,969	2,858,751	0.088140	667,687	58,850	90.00
91.00	Nursing School cost	0	2,858,751	0.000000	667,687	0	91.00
92.00	Allied health cost	0	2,858,751	0.000000	667,687	0	92.00
93.00	All other Medical Education	0	2,858,751	0.000000	667,687	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		754,361		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.253746	73,679	18,696	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164572	118,555	19,511	54.00
60.00	06000	LABORATORY	0.191338	222,781	42,626	60.00
65.00	06500	RESPIRATORY THERAPY	0.616051	286,723	176,636	65.00
66.00	06600	PHYSICAL THERAPY	0.396476	31,947	12,666	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.345973	8,565	2,963	67.00
68.00	06800	SPEECH PATHOLOGY	0.640792	5,715	3,662	68.00
69.00	06900	ELECTROCARDIOLOGY	0.212192	40,741	8,645	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.138611	130,540	18,094	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.599340	20,125	12,062	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270375	265,170	71,695	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.382034	2,257	862	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.032927	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,206,798	388,118	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)		1,206,798		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.253746	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164572	29,750	4,896	54.00
60.00	06000	LABORATORY	0.191338	104,117	19,922	60.00
65.00	06500	RESPIRATORY THERAPY	0.616051	92,023	56,691	65.00
66.00	06600	PHYSICAL THERAPY	0.396476	138,888	55,066	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.345973	104,565	36,177	67.00
68.00	06800	SPEECH PATHOLOGY	0.640792	6,748	4,324	68.00
69.00	06900	ELECTROCARDIOLOGY	0.212192	5,009	1,063	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.138611	23,790	3,298	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.599340	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270375	108,226	29,262	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.382034	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.032927	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		613,116	210,699	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)		613,116		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 10:22 am

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		175,547		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.253746	60,483	15,347	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164572	92,067	15,152	54.00
60.00	06000	LABORATORY	0.191338	91,307	17,470	60.00
65.00	06500	RESPIRATORY THERAPY	0.616051	57,182	35,227	65.00
66.00	06600	PHYSICAL THERAPY	0.396476	7,397	2,933	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.345973	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.640792	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.212192	14,864	3,154	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.138611	46,404	6,432	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.599340	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270375	91,471	24,731	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.382034	67,819	25,909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.032927	912	942	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		529,906	147,297	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)		529,906		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1309	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/26/2018 10:22 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,497,097	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)	4,497,097	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)	4,542,068	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 (for CAH, see instructions)	60,710	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,903,300	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)	1,578,058	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)	1,578,058	30.00
31.00	Primary payer payments	725	31.00
32.00	Subtotal (line 30 minus line 31)	1,577,333	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)	721,047	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	468,681	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	546,027	36.00
37.00	Subtotal (see instructions)	2,046,014	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)	2,046,014	40.00
40.01	Sequestration adjustment (see instructions)	40,920	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,758,018	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	247,076	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: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		905,301		1,758,018	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	01/31/2018	61,200		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)		61,200		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)		966,501		1,758,018	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		86,211		247,076	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,052,712		2,005,094	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: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/26/2018 10:22 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		850,800		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	01/31/2018	49,800		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)		49,800		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)		900,600		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		76,053		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		976,653		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 - SWING BEDS	Provider CCN: 15-1309 Component CCN: 15-Z309	Period: From 07/01/2017 To 06/30/2018	Worksheet E-2 Date/Time Prepared: 11/26/2018 10:22 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	787,940	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)	212,806	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	444	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)	1,000,746	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,000,746	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)	1,000,746	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,161	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)	996,585	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)	996,585	0	19.00
19.01	Sequestration adjustment (see instructions)	19,932	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	900,600	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)	76,053	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: 15-1309	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Prepared: 11/26/2018 10:22 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,184,071	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)	1,184,071	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,195,912	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)	1,195,912	19.00
20.00	Deductibles (exclude professional component)	135,384	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,060,528	22.00
23.00	Coinsurance	1,645	23.00
24.00	Subtotal (line 22 minus line 23)	1,058,883	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	23,558	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	15,313	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	5,677	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,074,196	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)	1,074,196	30.00
30.01	Sequestration adjustment (see instructions)	21,484	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	966,501	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)	86,211	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: 15-1309	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2018 10:22 am
	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	150,811		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)	150,811	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)	150,811	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	175,547		8.00
9.00	Ancillary service charges	529,906	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)	705,453	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)	705,453	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	554,642	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)	150,811	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)	150,811	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)	150,811	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)	150,811	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	150,811	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)	150,811	0	40.00
41.00	Interim payments	150,811	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/26/2018 10:22 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	80,484	0	0	0	1.00
2.00	Temporary investments	189,702	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,782,864	0	0	0	4.00
5.00	Other receivable	198,212	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,563,593	0	0	0	6.00
7.00	Inventory	427,904	0	0	0	7.00
8.00	Prepaid expenses	171,948	0	0	0	8.00
9.00	Other current assets	-267,546	0	0	0	9.00
10.00	Due from other funds	458,696	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,478,671	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,500	0	0	0	12.00
13.00	Land improvements	192,578	0	0	0	13.00
14.00	Accumulated depreciation	-191,316	0	0	0	14.00
15.00	Buildings	9,936,882	0	0	0	15.00
16.00	Accumulated depreciation	-4,438,563	0	0	0	16.00
17.00	Leasehold improvements	995,040	0	0	0	17.00
18.00	Accumulated depreciation	-555,954	0	0	0	18.00
19.00	Fixed equipment	3,057,492	0	0	0	19.00
20.00	Accumulated depreciation	-2,500,182	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	7,413,345	0	0	0	23.00
24.00	Accumulated depreciation	-5,716,541	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)	8,195,281	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	21,088	1,984,441	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	21,088	1,984,441	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	11,695,040	1,984,441	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,040,916	0	0	0	37.00
38.00	Salaries, wages, and fees payable	784,218	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	105,050	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,421,516	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,351,700	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,371,049	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)	7,371,049	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,722,749	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-27,709				52.00
53.00	Specific purpose fund		1,984,441			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)	-27,709	1,984,441	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,695,040	1,984,441	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/26/2018 10:22 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		861,655		1,888,829		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-188,563				2.00
3.00	Total (sum of line 1 and line 2)		673,092		1,888,829		3.00
4.00	PENSION COST ADJUSTMENT	0		0		0	4.00
5.00	CONTRIBUTIONS	0		48,882		0	5.00
6.00	RESTRICTED INVEST. INCOME - HSD	0		44,116		0	6.00
7.00	RESTRICTED INVEST. INCOME NON-HSD	0		4,642		0	7.00
8.00	TRANSFER FROM AFFLIATES	-700,801		0		0	8.00
9.00	ROUNDING	0		0		0	9.00
10.00	Total additions (sum of line 4-9)		-700,801		97,640		10.00
11.00	Subtotal (line 3 plus line 10)		-27,709		1,986,469		11.00
12.00	TRANSFER FROM AFFILIATES	0		24,680		0	12.00
13.00	UNREALIZED LOSSES- RESTRICTED HSD	0		0		0	13.00
14.00	UNREALIZED LOSSES RESTRICTED NON-HSD	0		-12,747		0	14.00
15.00	ROUNDING	0		-9,905		0	15.00
16.00	PENSION COST ADJUSTMENT	0		0		0	16.00
17.00	ROUNDING	0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		2,028		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-27,709		1,984,441		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	PENSION COST ADJUSTMENT		0				4.00
5.00	CONTRIBUTIONS		0				5.00
6.00	RESTRICTED INVEST. INCOME - HSD		0				6.00
7.00	RESTRICTED INVEST. INCOME NON-HSD		0				7.00
8.00	TRANSFER FROM AFFLIATES		0				8.00
9.00	ROUNDING		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	TRANSFER FROM AFFILIATES		0				12.00
13.00	UNREALIZED LOSSES- RESTRICTED HSD		0				13.00
14.00	UNREALIZED LOSSES RESTRICTED NON-HSD		0				14.00
15.00	ROUNDING		0				15.00
16.00	PENSION COST ADJUSTMENT		0				16.00
17.00	ROUNDING		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: 15-1309 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/26/2018 10:22 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,371,971		2,371,971	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)	2,371,971		2,371,971	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)	2,371,971		2,371,971	17.00
18.00	Ancillary services	2,993,938	42,178,211	45,172,149	18.00
19.00	Outpatient services	158,430	12,806,874	12,965,304	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				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,524,339	54,985,085	60,509,424	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,258,841		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)		18,258,841		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1309	Period: From 07/01/2017 To 06/30/2018	Worksheet G-3 Date/Time Prepared: 11/26/2018 10:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	60,509,424	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,616,658	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,892,766	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,258,841	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-366,075	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	-863	6.00
7.00	Income from investments	1,532	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	34,280	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	-60	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	119,391	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC. INCOME	18,230	24.00
24.01	ASSETS RELEASED FROM RESTRICTION	24,680	24.01
24.02	OTHER (SPECIFY)	0	24.02
24.03	UNREALIZED LOSS	0	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
25.00	Total other income (sum of lines 6-24)	197,190	25.00
26.00	Total (line 5 plus line 25)	-168,885	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
27.01	FUNDRAISING EXPENSES	19,678	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	19,678	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-188,563	29.00