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: 15-1335	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/26/2018 4:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/26/2018 Time: 4:05 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 DUNN (15-1335) 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	-289,478	137,005	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	-69,389	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-358,867	137,005	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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2018 4:45 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1616 TWENTY-THIRD STREET	PO Box:			1.00
2.00	City: BEDFORD	State: IN	Zip Code: 47421	County: LAWRENCE	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 DUNN	151335	99915	1	07/01/1966	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 DUNN	15Z335	99915		03/03/2012	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)	2		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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2018 4:45 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2018 4:45 pm

		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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2018 4:45 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1335	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/21/2018 4:45 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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	N	N	N	109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1335	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/21/2018 4:45 pm

		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:	77,426	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2018 4:45 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 250 WEST 96TH STREET SUITE 215	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	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)	10/01/2016	09/30/2017	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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2018 4:45 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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	10/15/2018	Y	10/15/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 11/21/2018 4:45 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1335	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/21/2018 4:45 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 11/21/2018 4:45 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	43,344.00	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	43,344.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	43,344.00	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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2018 4:45 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	744	72	1,675			1.00
2.00	HMO and other (see instructions)	150	467				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	168	0	225			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)	912	72	1,900			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		26	621			13.00
14.00	Total (see instructions)	912	98	2,521	0.00	90.67	14.00
15.00	CAH visits	9,923	722	32,876			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	90.67	27.00
28.00	Observation Bed Days		0	321			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			21			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	5	110			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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 11/21/2018 4:45 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	193	37	602	1.00
2.00	HMO and other (see instructions)			39	193		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	193	37	602	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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/21/2018 4:45 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.367427	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,888,342	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	15,600,665	6.00
7.00	Medicaid cost (line 1 times line 6)	5,732,106	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,843,764	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,843,764	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)	2,509,164	922,999	3,432,163	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	921,935	922,999	1,844,934	21.00
22.00	Payments received from patients for amounts previously written off as charity care	71,650	19,178	90,828	22.00
23.00	Cost of charity care (line 21 minus line 22)	850,285	903,821	1,754,106	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)	1,066,989	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	414,157	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	637,164	27.01
28.00	Non-Medicare bad debt expense (see instructions)	429,825	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	380,936	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,135,042	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,978,806	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/21/2018 4:45 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		617,006	617,006	-3,294	613,712	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		367,901	367,901	0	367,901	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-47,968	1,791,225	1,743,257	0	1,743,257	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	756,745	4,465,304	5,222,049	3,294	5,225,343	5.00
7.00	00700	OPERATION OF PLANT	0	1,296,064	1,296,064	0	1,296,064	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	78,979	78,979	0	78,979	8.00
9.00	00900	HOUSEKEEPING	0	398,867	398,867	0	398,867	9.00
10.00	01000	DIETARY	-195	498,308	498,113	-360,766	137,347	10.00
11.00	01100	CAFETERIA	0	0	0	360,766	360,766	11.00
13.00	01300	NURSING ADMINISTRATION	221,538	55,090	276,628	0	276,628	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,291	21,291	0	21,291	14.00
15.00	01500	PHARMACY	219,393	365,940	585,333	-24	585,309	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,254	16,254	0	16,254	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,886,476	228,047	2,114,523	-859,593	1,254,930	30.00
43.00	04300	NURSERY	0	0	0	275,830	275,830	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	603,637	505,516	1,109,153	-129,710	979,443	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	576,969	576,969	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	630,590	307,443	938,033	-450	937,583	54.00
60.00	06000	LABORATORY	0	1,507,674	1,507,674	0	1,507,674	60.00
65.00	06500	RESPIRATORY THERAPY	354,437	13,784	368,221	0	368,221	65.00
66.00	06600	PHYSICAL THERAPY	44,002	232,581	276,583	-881	275,702	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	471	471	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	410	410	68.00
69.00	06900	ELECTROCARDIOLOGY	200,337	1,315	201,652	0	201,652	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	35,557	35,557	137,929	173,486	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	73,810	73,810	0	73,810	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	9,493	974	10,467	0	10,467	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	493,151	493,151	0	493,151	76.00
76.97	07697	CARDIAC REHABILITATION	10,912	3,205	14,117	0	14,117	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	811,649	1,175,415	1,987,064	-951	1,986,113	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)	5,701,046	14,550,701	20,251,747	0	20,251,747	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
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	42,769	683	43,452	0	43,452	194.01
194.02	07952	COMMUNITY OUTREACH	0	1,582	1,582	0	1,582	194.02
194.03	07953	WIC	249	0	249	0	249	194.03
194.04	07954	GRANTS	0	17,375	17,375	0	17,375	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0	194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	5,744,064	14,570,341	20,314,405	0	20,314,405	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/21/2018 4:45 pm

		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	-149,127	464,585		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	367,901		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	30,839	1,774,096		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	622,536	5,847,879		5.00
7.00	00700	OPERATION OF PLANT	0	1,296,064		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	78,979		8.00
9.00	00900	HOUSEKEEPING	0	398,867		9.00
10.00	01000	DIETARY	0	137,347		10.00
11.00	01100	CAFETERIA	-65,320	295,446		11.00
13.00	01300	NURSING ADMINISTRATION	-186	276,442		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,522	22,813		14.00
15.00	01500	PHARMACY	-27	585,282		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,221	11,033		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-131	1,254,799		30.00
43.00	04300	NURSERY	0	275,830		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,269	978,174		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-175	576,794		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	937,583		54.00
60.00	06000	LABORATORY	-2,500	1,505,174		60.00
65.00	06500	RESPIRATORY THERAPY	0	368,221		65.00
66.00	06600	PHYSICAL THERAPY	0	275,702		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	471		67.00
68.00	06800	SPEECH PATHOLOGY	0	410		68.00
69.00	06900	ELECTROCARDIOLOGY	-19,126	182,526		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	173,486		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	73,810		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SLEEP DISORDER	0	10,467		75.01
76.00	03950	SENIOR RENEWAL CENTER	0	493,151		76.00
76.97	07697	CARDIAC REHABILITATION	0	14,117		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	1,986,113		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)	411,815	20,663,562		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	MARKETING	0	0		194.00
194.01	07951	FOUNDATION	0	43,452		194.01
194.02	07952	COMMUNITY OUTREACH	0	1,582		194.02
194.03	07953	WIC	92,578	92,827		194.03
194.04	07954	GRANTS	0	17,375		194.04
194.05	07955	VACANT SPACE	0	0		194.05
194.06	07956	OLD AMBULANCE CENTER	0	0		194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	504,393	20,818,798		200.00

RECLASSIFICATIONS | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/21/2018 4:45 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	0	360,766		1.00
	TOTALS		0	360,766		
	B - INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,294		1.00
	TOTALS		0	3,294		
	C - NURSERY AND L&D					
1.00	NURSERY	43.00	244,022	31,808		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	510,435	66,534		2.00
	TOTALS		754,457	98,342		
	D - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	137,929		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	137,929		
	E - THERAPY EXPENSES					
1.00	OCCUPATIONAL THERAPY	67.00	471	0		1.00
2.00	SPEECH PATHOLOGY	68.00	410	0		2.00
	TOTALS		881	0		
	F - DIETARY SALARY					
1.00	DIETARY	10.00	195	0		1.00
	TOTALS		195	0		
500.00	Grand Total: Increases		755,533	600,331		500.00

RECLASSIFICATIONS | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/21/2018 4:45 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	0	360,766	0		1.00
	TOTALS		0	360,766			
	B - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,294	9		1.00
	TOTALS		0	3,294			
	C - NURSERY AND L&D						
1.00	ADULTS & PEDIATRICS	30.00	754,457	98,342	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		754,457	98,342			
	D - MEDICAL SUPPLIES						
1.00	PHARMACY	15.00	0	24	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	6,794	0		2.00
3.00	OPERATING ROOM	50.00	0	129,710	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	450	0		4.00
5.00	EMERGENCY	91.00	0	951	0		5.00
	TOTALS		0	137,929			
	E - THERAPY EXPENSES						
1.00	PHYSICAL THERAPY	66.00	881	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		881	0			
	F - DIETARY SALARY						
1.00	DIETARY	10.00	0	195	0		1.00
	TOTALS		0	195			
500.00	Grand Total: Decreases		755,338	600,526			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/21/2018 4:45 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	100,000	0	0	0	0	1.00
2.00	Land Improvements	83,405	0	0	0	0	2.00
3.00	Buildings and Fixtures	5,546,056	1,192,973	0	1,192,973	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,687,940	119,313	0	119,313	0	5.00
6.00	Movable Equipment	3,592,084	373,183	0	373,183	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,009,485	1,685,469	0	1,685,469	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	12,009,485	1,685,469	0	1,685,469	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	100,000	0	1.00
2.00	Land Improvements	83,405	0	2.00
3.00	Buildings and Fixtures	6,739,029	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,807,253	0	5.00
6.00	Movable Equipment	3,965,267	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,694,954	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	13,694,954	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 11/21/2018 4:45 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	325,232	0	266,342	24,723	709	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	367,596	0	0	305	0	2.00
3.00	Total (sum of lines 1-2)	692,828	0	266,342	25,028	709	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	617,006		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	367,901		2.00
3.00	Total (sum of lines 1-2)	0	984,907		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/21/2018 4:45 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: 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	6,922,434	0	6,922,434	0.505473	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,772,520	0	6,772,520	0.494527	0	2.00
3.00	Total (sum of lines 1-2)	13,694,954	0	13,694,954	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: 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	321,938	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	367,596	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	689,534	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	117,215	24,723	709	0	464,585	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	305	0	0	367,901	2.00
3.00	Total (sum of lines 1-2)	117,215	25,028	709	0	832,486	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/21/2018 4:45 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-149,127	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-1,867	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	-65,395			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	1,766,282			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-65,320	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,221	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
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	BIOTERRORISM GRANT	B	-11,589	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/21/2018 4:45 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	ADVERTISING	A	-2,600	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PROMOTIONAL ITEMS	A	-4,520	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	CHARITABLE EXPENSE OTHER	A	-590	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MARKETING	A	-186	NURSING ADMINISTRATION	13.00	0	33.04
33.05	LATE PENALTY FEES	A	-150	CENTRAL SERVICES & SUPPLY	14.00	0	33.05
33.06	ENTERTAINMENT	A	-131	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	PAYROLL INCENTIVE	B	-1,525	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	ADMINISTRATVIE & GENERAL	B	-446	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	INVENTORY	B	1,672	CENTRAL SERVICES & SUPPLY	14.00	0	33.09
33.10	MISC REVENUE	B	-27	PHARMACY	15.00	0	33.10
33.11	MISC REVENUE	B	-175	DELIVERY ROOM & LABOR ROOM	52.00	0	33.11
33.12	MISC REVENUE	B	-2,500	LABORATORY	60.00	0	33.12
33.13	HOSPITAL PROVIDER TAX	B	-945,766	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	LOBBYING OFFSET	A	-312	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	ACCRUED INCENTIVES	A	32,364	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	CORPORATE SPONSORSHIP	A	-35,428	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	COMMUNITY BENEFIT EXPENSE	A	-3,050	ADMINISTRATIVE & GENERAL	5.00	0	33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		504,393				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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/21/2018 4:45 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	326,035	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	4,624,053	3,276,384	2.00
3.00	194.03	WIC	HOME OFFICE - MARKETING	92,578	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	145,354	145,354	3.01
3.02	13.00	NURSING ADMINISTRATION	SVH CHARGEBACKS	960	960	3.02
3.03	15.00	PHARMACY	SVH CHARGEBACKS	28,897	28,897	3.03
3.04	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	25,353	25,353	3.04
3.05	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	266,342	266,342	3.05
3.06	0.00			0	0	3.06
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,509,572	3,743,290	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	G	ASCENSION	100.00	ASCENSION	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	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: 15-1335	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-1 Date/Time Prepared: 11/21/2018 4:45 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	326,035	0		1.00
2.00	1,347,669	0		2.00
3.00	92,578	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	9		3.05
3.06	0	0		3.06
4.00	0	0		4.00
5.00	1,766,282			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	ADMINISTRATION		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/21/2018 4:45 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	45,000	45,000	0	0	0	1.00
2.00	50.00	OPERATING ROOM	1,269	1,269	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	19,126	19,126	0	0	0	3.00
4.00	91.00	EMERGENCY	1,097,477	0	1,097,477	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			1,162,872	65,395	1,097,477		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	45,000		1.00
2.00	50.00	OPERATING ROOM	0	0	0	1,269		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	19,126		3.00
4.00	91.00	EMERGENCY	0	0	0	0		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	65,395		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1335	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/21/2018 4:45 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					50	1.00
2.00	Line 1 multiplied by 15 hours per week					750	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					216	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					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	1,986.00	859.00	840.00	1,477.00	0.00	9.00
10.00	AHSEA (see instructions)	94.15	81.87	53.21	53.21	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)					186,982	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					70,326	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					44,696	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					302,004	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					78,591	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)					380,595	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)					380,595	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)					8,843	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)					8,843	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)					2,067	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					10,910	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)					10,910	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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2018 4:45 pm

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	53.21	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)	380,595	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	10,910	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)	391,505	63.00
64.00	Total cost of outside supplier services (from your records)	227,665	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	8,843	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,067	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	10,910	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	2,067	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	2,067	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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/21/2018 4:45 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	464,585	464,585				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	367,901		367,901			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,774,096	1,970	1,560	1,777,626		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,847,879	43,109	34,138	232,244	6,157,370	5.00
7.00	00700	OPERATION OF PLANT	1,296,064	60,670	48,047	0	1,404,781	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	78,979	6,403	5,070	0	90,452	8.00
9.00	00900	HOUSEKEEPING	398,867	6,500	5,147	0	410,514	9.00
10.00	01000	DIETARY	137,347	21,453	16,989	0	175,789	10.00
11.00	01100	CAFETERIA	295,446	0	0	0	295,446	11.00
13.00	01300	NURSING ADMINISTRATION	276,442	7,265	5,753	67,990	357,450	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22,813	14,826	11,740	0	49,379	14.00
15.00	01500	PHARMACY	585,282	8,247	6,531	67,331	667,391	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,033	23,070	18,269	0	52,372	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,254,799	39,681	31,423	347,414	1,673,317	30.00
43.00	04300	NURSERY	275,830	2,356	1,866	74,890	354,942	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	978,174	48,959	38,770	185,256	1,251,159	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	576,794	29,982	23,742	156,652	787,170	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	937,583	34,857	27,603	193,527	1,193,570	54.00
60.00	06000	LABORATORY	1,505,174	12,332	9,765	0	1,527,271	60.00
65.00	06500	RESPIRATORY THERAPY	368,221	8,311	6,581	108,776	491,889	65.00
66.00	06600	PHYSICAL THERAPY	275,702	13,007	10,300	13,234	312,243	66.00
67.00	06700	OCCUPATIONAL THERAPY	471	1,271	1,007	145	2,894	67.00
68.00	06800	SPEECH PATHOLOGY	410	686	543	126	1,765	68.00
69.00	06900	ELECTROCARDIOLOGY	182,526	7,843	6,211	61,483	258,063	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	173,486	0	0	0	173,486	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,810	0	0	0	73,810	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	10,467	5,505	4,359	2,913	23,244	75.01
76.00	03950	SENIOR RENEWAL CENTER	493,151	10,030	7,942	0	511,123	76.00
76.97	07697	CARDIAC REHABILITATION	14,117	1,532	1,213	3,349	20,211	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,986,113	22,361	17,708	249,094	2,275,276	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)	20,663,562	432,226	342,277	1,764,424	20,592,377	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,599	1,266	0	2,865	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	30,184	23,902	0	54,086	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	43,452	576	456	13,126	57,610	194.01
194.02	07952	COMMUNITY OUTREACH	1,582	0	0	0	1,582	194.02
194.03	07953	WIC	92,827	0	0	76	92,903	194.03
194.04	07954	GRANTS	17,375	0	0	0	17,375	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0	194.06
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)	20,818,798	464,585	367,901	1,777,626	20,818,798	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/21/2018 4:45 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,157,370					5.00
7.00	00700	OPERATION OF PLANT	589,967	1,994,748				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	37,987	32,959	161,398			8.00
9.00	00900	HOUSEKEEPING	172,404	33,459	0	616,377		9.00
10.00	01000	DIETARY	73,826	110,437	0	35,300	395,352	10.00
11.00	01100	CAFETERIA	124,079	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	150,119	37,396	0	11,953	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,738	76,319	0	24,395	0	14.00
15.00	01500	PHARMACY	280,285	42,452	0	13,570	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,995	118,759	0	37,960	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	702,745	204,269	34,263	65,293	395,352	30.00
43.00	04300	NURSERY	149,065	12,127	13,164	3,876	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	525,450	252,028	23,738	80,561	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	330,589	154,338	27,529	49,333	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	501,265	179,435	11,928	57,355	0	54.00
60.00	06000	LABORATORY	641,410	63,481	0	20,291	0	60.00
65.00	06500	RESPIRATORY THERAPY	206,579	42,782	0	13,675	0	65.00
66.00	06600	PHYSICAL THERAPY	131,133	66,957	10,964	21,402	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,215	6,544	1,066	2,092	0	67.00
68.00	06800	SPEECH PATHOLOGY	741	3,529	17	1,128	0	68.00
69.00	06900	ELECTROCARDIOLOGY	108,379	40,372	6,091	12,905	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	72,859	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,998	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	9,762	28,337	0	9,058	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	214,657	51,630	0	16,503	0	76.00
76.97	07697	CARDIAC REHABILITATION	8,488	7,887	0	2,521	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	955,544	115,111	32,638	36,794	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)	6,062,279	1,680,608	161,398	515,965	395,352	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,203	8,230	0	2,631	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,715	244,918	0	78,286	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	24,195	2,963	0	947	0	194.01
194.02	07952	COMMUNITY OUTREACH	664	23,214	0	7,420	0	194.02
194.03	07953	WIC	39,017	22,056	0	7,050	0	194.03
194.04	07954	GRANTS	7,297	12,759	0	4,078	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,157,370	1,994,748	161,398	616,377	395,352	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/21/2018 4:45 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	419,525					11.00
13.00	01300	NURSING ADMINISTRATION	16,393	573,311				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	170,831			14.00
15.00	01500	PHARMACY	13,751	0	0	1,017,449		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	231,086	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	99,508	204,752	9,485	0	11,266	30.00
43.00	04300	NURSERY	19,276	39,661	3,549	0	3,664	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,510	108,045	63,938	0	53,419	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	40,321	82,965	7,425	0	7,667	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,942	0	6,307	0	51,632	54.00
60.00	06000	LABORATORY	0	0	0	0	44,291	60.00
65.00	06500	RESPIRATORY THERAPY	26,874	0	0	0	3,004	65.00
66.00	06600	PHYSICAL THERAPY	2,802	0	0	0	6,754	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	660	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	7	68.00
69.00	06900	ELECTROCARDIOLOGY	15,989	0	0	0	7,556	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	45,834	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	21,960	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,017,449	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	842	0	0	0	306	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	0	4,165	76.00
76.97	07697	CARDIAC REHABILITATION	896	0	0	0	1,476	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	67,014	137,888	12,333	0	35,219	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)	415,118	573,311	170,831	1,017,449	231,086	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
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	4,407	0	0	0	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0	194.06
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)	419,525	573,311	170,831	1,017,449	231,086	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/21/2018 4:45 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,400,250	0	3,400,250		30.00
43.00	04300	NURSERY	599,324	0	599,324		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,410,848	0	2,410,848		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,487,337	0	1,487,337		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,060,434	0	2,060,434		54.00
60.00	06000	LABORATORY	2,296,744	0	2,296,744		60.00
65.00	06500	RESPIRATORY THERAPY	784,803	0	784,803		65.00
66.00	06600	PHYSICAL THERAPY	552,255	0	552,255		66.00
67.00	06700	OCCUPATIONAL THERAPY	14,471	0	14,471		67.00
68.00	06800	SPEECH PATHOLOGY	7,187	0	7,187		68.00
69.00	06900	ELECTROCARDIOLOGY	449,355	0	449,355		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	292,179	0	292,179		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	126,768	0	126,768		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,017,449	0	1,017,449		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SLEEP DISORDER	71,549	0	71,549		75.01
76.00	03950	SENIOR RENEWAL CENTER	798,078	0	798,078		76.00
76.97	07697	CARDIAC REHABILITATION	41,479	0	41,479		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,667,817	0	3,667,817		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)	20,078,327	0	20,078,327		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,929	0	14,929		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	400,005	0	400,005		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	MARKETING	0	0	0		194.00
194.01	07951	FOUNDATION	90,122	0	90,122		194.01
194.02	07952	COMMUNITY OUTREACH	32,880	0	32,880		194.02
194.03	07953	WIC	161,026	0	161,026		194.03
194.04	07954	GRANTS	41,509	0	41,509		194.04
194.05	07955	VACANT SPACE	0	0	0		194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0		194.06
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	20,818,798	0	20,818,798		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/21/2018 4:45 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,970	1,560	3,530	3,530	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	330,537	43,109	34,138	407,784	461	5.00
7.00	00700	OPERATION OF PLANT	0	60,670	48,047	108,717	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,403	5,070	11,473	0	8.00
9.00	00900	HOUSEKEEPING	0	6,500	5,147	11,647	0	9.00
10.00	01000	DIETARY	0	21,453	16,989	38,442	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,265	5,753	13,018	135	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,826	11,740	26,566	0	14.00
15.00	01500	PHARMACY	45,902	8,247	6,531	60,680	134	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,070	18,269	41,339	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,283	39,681	31,423	114,387	691	30.00
43.00	04300	NURSERY	0	2,356	1,866	4,222	149	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,320	48,959	38,770	129,049	368	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	29,982	23,742	53,724	311	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	222,980	34,857	27,603	285,440	384	54.00
60.00	06000	LABORATORY	0	12,332	9,765	22,097	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,142	8,311	6,581	20,034	216	65.00
66.00	06600	PHYSICAL THERAPY	0	13,007	10,300	23,307	26	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,271	1,007	2,278	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	686	543	1,229	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,843	6,211	14,054	122	69.00
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	477	5,505	4,359	10,341	6	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	10,030	7,942	17,972	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,532	1,213	2,745	7	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	22,361	17,708	40,069	494	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)	689,641	432,226	342,277	1,464,144	3,504	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,599	1,266	2,865	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	30,184	23,902	54,086	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	576	456	1,032	26	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0	194.06
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)	689,641	464,585	367,901	1,522,127	3,530	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/21/2018 4:45 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	408,245					5.00
7.00	00700	OPERATION OF PLANT	39,116	147,833				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,519	2,443	16,435			8.00
9.00	00900	HOUSEKEEPING	11,431	2,480	0	25,558		9.00
10.00	01000	DIETARY	4,895	8,185	0	1,464	52,986	10.00
11.00	01100	CAFETERIA	8,227	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,953	2,771	0	496	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,375	5,656	0	1,012	0	14.00
15.00	01500	PHARMACY	18,584	3,146	0	563	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,458	8,801	0	1,574	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,594	15,139	3,489	2,707	52,986	30.00
43.00	04300	NURSERY	9,883	899	1,340	161	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,839	18,676	2,417	3,339	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,919	11,438	2,803	2,046	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,235	13,298	1,215	2,378	0	54.00
60.00	06000	LABORATORY	42,527	4,705	0	841	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,697	3,171	0	567	0	65.00
66.00	06600	PHYSICAL THERAPY	8,694	4,962	1,116	887	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	81	485	109	87	0	67.00
68.00	06800	SPEECH PATHOLOGY	49	262	2	47	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,186	2,992	620	535	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,831	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,055	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	647	2,100	0	376	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	14,232	3,826	0	684	0	76.00
76.97	07697	CARDIAC REHABILITATION	563	585	0	105	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	63,350	8,531	3,324	1,526	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)	401,940	124,551	16,435	21,395	52,986	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	80	610	0	109	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,506	18,151	0	3,246	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	1,604	220	0	39	0	194.01
194.02	07952	COMMUNITY OUTREACH	44	1,720	0	308	0	194.02
194.03	07953	WIC	2,587	1,635	0	292	0	194.03
194.04	07954	GRANTS	484	946	0	169	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0	194.06
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)	408,245	147,833	16,435	25,558	52,986	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/21/2018 4:45 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	8,227					11.00
13.00	01300	NURSING ADMINISTRATION	321	26,694				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	34,609			14.00
15.00	01500	PHARMACY	270	0	0	83,377		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	53,172	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,950	9,533	1,922	0	2,593	30.00
43.00	04300	NURSERY	378	1,847	719	0	843	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,030	5,031	12,952	0	12,280	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	791	3,863	1,504	0	1,765	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,156	0	1,278	0	11,884	54.00
60.00	06000	LABORATORY	0	0	0	0	10,194	60.00
65.00	06500	RESPIRATORY THERAPY	527	0	0	0	691	65.00
66.00	06600	PHYSICAL THERAPY	55	0	0	0	1,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	152	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2	68.00
69.00	06900	ELECTROCARDIOLOGY	314	0	0	0	1,739	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	9,286	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,449	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	83,377	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	17	0	0	0	70	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	0	959	76.00
76.97	07697	CARDIAC REHABILITATION	18	0	0	0	340	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,314	6,420	2,499	0	8,106	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)	8,141	26,694	34,609	83,377	53,172	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
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	86	0	0	0	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0	194.06
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)	8,227	26,694	34,609	83,377	53,172	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/21/2018 4:45 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	251,991	0	251,991		30.00
43.00	04300	NURSERY	20,441	0	20,441		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	219,981	0	219,981		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	100,164	0	100,164		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	350,268	0	350,268		54.00
60.00	06000	LABORATORY	80,364	0	80,364		60.00
65.00	06500	RESPIRATORY THERAPY	38,903	0	38,903		65.00
66.00	06600	PHYSICAL THERAPY	40,601	0	40,601		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,192	0	3,192		67.00
68.00	06800	SPEECH PATHOLOGY	1,591	0	1,591		68.00
69.00	06900	ELECTROCARDIOLOGY	27,562	0	27,562		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,117	0	14,117		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,504	0	6,504		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83,377	0	83,377		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SLEEP DISORDER	13,557	0	13,557		75.01
76.00	03950	SENIOR RENEWAL CENTER	37,673	0	37,673		76.00
76.97	07697	CARDIAC REHABILITATION	4,363	0	4,363		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	135,633	0	135,633		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)	1,430,282	0	1,430,282		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,664	0	3,664		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	76,989	0	76,989		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	MARKETING	0	0	0		194.00
194.01	07951	FOUNDATION	3,007	0	3,007		194.01
194.02	07952	COMMUNITY OUTREACH	2,072	0	2,072		194.02
194.03	07953	WIC	4,514	0	4,514		194.03
194.04	07954	GRANTS	1,599	0	1,599		194.04
194.05	07955	VACANT SPACE	0	0	0		194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0		194.06
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,522,127	0	1,522,127		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/21/2018 4:45 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	181,625					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		181,625				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	770	770	5,792,227			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,853	16,853	756,745	-6,157,370	14,661,428	5.00
7.00	00700	OPERATION OF PLANT	23,720	23,720	0	0	1,404,781	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,503	2,503	0	0	90,452	8.00
9.00	00900	HOUSEKEEPING	2,541	2,541	0	0	410,514	9.00
10.00	01000	DIETARY	8,387	8,387	0	0	175,789	10.00
11.00	01100	CAFETERIA	0	0	0	0	295,446	11.00
13.00	01300	NURSING ADMINISTRATION	2,840	2,840	221,538	0	357,450	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,796	5,796	0	0	49,379	14.00
15.00	01500	PHARMACY	3,224	3,224	219,393	0	667,391	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,019	9,019	0	0	52,372	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,513	15,513	1,132,019	0	1,673,317	30.00
43.00	04300	NURSERY	921	921	244,022	0	354,942	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,140	19,140	603,637	0	1,251,159	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,721	11,721	510,435	0	787,170	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,627	13,627	630,590	0	1,193,570	54.00
60.00	06000	LABORATORY	4,821	4,821	0	0	1,527,271	60.00
65.00	06500	RESPIRATORY THERAPY	3,249	3,249	354,437	0	491,889	65.00
66.00	06600	PHYSICAL THERAPY	5,085	5,085	43,121	0	312,243	66.00
67.00	06700	OCCUPATIONAL THERAPY	497	497	471	0	2,894	67.00
68.00	06800	SPEECH PATHOLOGY	268	268	410	0	1,765	68.00
69.00	06900	ELECTROCARDIOLOGY	3,066	3,066	200,337	0	258,063	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	173,486	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	73,810	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	2,152	2,152	9,493	0	23,244	75.01
76.00	03950	SENIOR RENEWAL CENTER	3,921	3,921	0	0	511,123	76.00
76.97	07697	CARDIAC REHABILITATION	599	599	10,912	0	20,211	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,742	8,742	811,649	0	2,275,276	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)	168,975	168,975	5,749,209	-6,157,370	14,435,007	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	625	625	0	0	2,865	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,800	11,800	0	0	54,086	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	225	225	42,769	0	57,610	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	1,582	194.02
194.03	07953	WIC	0	0	249	0	92,903	194.03
194.04	07954	GRANTS	0	0	0	0	17,375	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0	194.06
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)	464,585	367,901	1,777,626		6,157,370	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.557935	2.025608	0.306899		0.419971	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,530		408,245	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000609		0.027845	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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/21/2018 4:45 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (PAID HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	151,489					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,503	9,539				8.00
9.00	00900	HOUSEKEEPING	2,541	0	146,445			9.00
10.00	01000	DIETARY	8,387	0	8,387	1,696		10.00
11.00	01100	CAFETERIA	0	0	0	0	154,986	11.00
13.00	01300	NURSING ADMINISTRATION	2,840	0	2,840	0	6,056	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,796	0	5,796	0	0	14.00
15.00	01500	PHARMACY	3,224	0	3,224	0	5,080	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,019	0	9,019	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,513	2,025	15,513	1,696	36,762	30.00
43.00	04300	NURSERY	921	778	921	0	7,121	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,140	1,403	19,140	0	19,399	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,721	1,627	11,721	0	14,896	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,627	705	13,627	0	21,775	54.00
60.00	06000	LABORATORY	4,821	0	4,821	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,249	0	3,249	0	9,928	65.00
66.00	06600	PHYSICAL THERAPY	5,085	648	5,085	0	1,035	66.00
67.00	06700	OCCUPATIONAL THERAPY	497	63	497	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	268	1	268	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,066	360	3,066	0	5,907	69.00
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	2,152	0	2,152	0	311	75.01
76.00	03950	SENIOR RENEWAL CENTER	3,921	0	3,921	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	599	0	599	0	331	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,742	1,929	8,742	0	24,757	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)	127,632	9,539	122,588	1,696	153,358	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	625	0	625	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,600	0	18,600	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	225	0	225	0	1,628	194.01
194.02	07952	COMMUNITY OUTREACH	1,763	0	1,763	0	0	194.02
194.03	07953	WIC	1,675	0	1,675	0	0	194.03
194.04	07954	GRANTS	969	0	969	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,994,748	161,398	616,377	395,352	419,525	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.167610	16.919803	4.208932	233.108491	2.706857	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	147,833	16,435	25,558	52,986	8,227	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.975866	1.722927	0.174523	31.241745	0.053082	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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/21/2018 4:45 pm

		Cost Center Description	NURSING ADMINISTRATION (PAID HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	102,935					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	574,169				14.00
15.00	01500	PHARMACY	0	0	10,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	50,803,140		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,762	31,881	0	2,476,659		30.00
43.00	04300	NURSERY	7,121	11,930	0	805,438		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,399	214,892	0	11,746,540		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,896	24,955	0	1,685,321		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,198	0	11,350,205		54.00
60.00	06000	LABORATORY	0	0	0	9,736,458		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	660,447		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,484,718		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	144,989		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,525		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,661,094		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	154,050	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	73,810	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	10,000	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0	0	67,327		75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	915,683		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	324,540		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	24,757	41,453	0	7,742,196		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)	102,935	574,169	10,000	50,803,140		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	MARKETING	0	0	0	0		194.00
194.01	07951	FOUNDATION	0	0	0	0		194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0		194.02
194.03	07953	WIC	0	0	0	0		194.03
194.04	07954	GRANTS	0	0	0	0		194.04
194.05	07955	VACANT SPACE	0	0	0	0		194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0		194.06
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)	573,311	170,831	1,017,449	231,086		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.569641	0.297527	101.744900	0.004549		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	26,694	34,609	83,377	53,172		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.259329	0.060277	8.337700	0.001047		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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/21/2018 4:45 pm

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	3,400,250		3,400,250	0	0	30.00
43.00	04300	NURSERY	599,324		599,324	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,410,848		2,410,848	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,487,337		1,487,337	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,060,434		2,060,434	0	0	54.00
60.00	06000	LABORATORY	2,296,744		2,296,744	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	784,803	0	784,803	0	0	65.00
66.00	06600	PHYSICAL THERAPY	552,255	0	552,255	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,471	0	14,471	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,187	0	7,187	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	449,355		449,355	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	292,179		292,179	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	126,768		126,768	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,017,449		1,017,449	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	SLEEP DISORDER	71,549		71,549	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	798,078		798,078	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	41,479		41,479	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,667,817		3,667,817	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	491,435		491,435		0	92.00
200.00		Subtotal (see instructions)	20,569,762	0	20,569,762	0	0	200.00
201.00		Less Observation Beds	491,435		491,435		0	201.00
202.00		Total (see instructions)	20,078,327	0	20,078,327	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/21/2018 4:45 pm

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	1,446,224		1,446,224			30.00
43.00	04300	NURSERY	805,438		805,438			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,968,225	9,777,030	11,745,255	0.205261	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,294,152	390,629	1,684,781	0.882807	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	370,180	10,773,599	11,143,779	0.184895	0.000000	54.00
60.00	06000	LABORATORY	769,322	8,962,467	9,731,789	0.236004	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	325,430	335,017	660,447	1.188291	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	171,946	1,312,771	1,484,717	0.371960	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,938	99,051	144,989	0.099808	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	847	847	8.485242	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	126,367	1,534,727	1,661,094	0.270518	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	472,449	1,042,952	1,515,401	0.192806	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	61,749	206,753	268,502	0.472131	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,109,799	1,937,224	3,047,023	0.333916	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	SLEEP DISORDER	0	67,327	67,327	1.062709	0.000000	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	915,683	915,683	0.871566	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	324,540	324,540	0.127809	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	133,551	7,608,645	7,742,196	0.473744	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	10,080	245,616	255,696	1.921950	0.000000	92.00
200.00		Subtotal (see instructions)	9,110,850	45,534,878	54,645,728			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,110,850	45,534,878	54,645,728			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/21/2018 4:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
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
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501	SLEEP DISORDER	0.000000		75.01
76.00	03950	SENIOR RENEWAL CENTER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/21/2018 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,400,250		3,400,250	0	3,400,250	30.00
43.00	04300	NURSERY	599,324		599,324	0	599,324	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,410,848		2,410,848	0	2,410,848	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,487,337		1,487,337	0	1,487,337	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,060,434		2,060,434	0	2,060,434	54.00
60.00	06000	LABORATORY	2,296,744		2,296,744	0	2,296,744	60.00
65.00	06500	RESPIRATORY THERAPY	784,803	0	784,803	0	784,803	65.00
66.00	06600	PHYSICAL THERAPY	552,255	0	552,255	0	552,255	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,471	0	14,471	0	14,471	67.00
68.00	06800	SPEECH PATHOLOGY	7,187	0	7,187	0	7,187	68.00
69.00	06900	ELECTROCARDIOLOGY	449,355		449,355	0	449,355	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	292,179		292,179	0	292,179	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	126,768		126,768	0	126,768	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,017,449		1,017,449	0	1,017,449	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	SLEEP DISORDER	71,549		71,549	0	71,549	75.01
76.00	03950	SENIOR RENEWAL CENTER	798,078		798,078	0	798,078	76.00
76.97	07697	CARDIAC REHABILITATION	41,479		41,479	0	41,479	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,667,817		3,667,817	0	3,667,817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	491,435		491,435		491,435	92.00
200.00		Subtotal (see instructions)	20,569,762	0	20,569,762	0	20,569,762	200.00
201.00		Less Observation Beds	491,435		491,435		491,435	201.00
202.00		Total (see instructions)	20,078,327	0	20,078,327	0	20,078,327	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/21/2018 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,446,224		1,446,224			30.00
43.00	04300	NURSERY	805,438		805,438			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,968,225	9,777,030	11,745,255	0.205261	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,294,152	390,629	1,684,781	0.882807	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	370,180	10,773,599	11,143,779	0.184895	0.000000	54.00
60.00	06000	LABORATORY	769,322	8,962,467	9,731,789	0.236004	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	325,430	335,017	660,447	1.188291	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	171,946	1,312,771	1,484,717	0.371960	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,938	99,051	144,989	0.099808	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	847	847	8.485242	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	126,367	1,534,727	1,661,094	0.270518	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	472,449	1,042,952	1,515,401	0.192806	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	61,749	206,753	268,502	0.472131	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,109,799	1,937,224	3,047,023	0.333916	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	SLEEP DISORDER	0	67,327	67,327	1.062709	0.000000	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	915,683	915,683	0.871566	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	324,540	324,540	0.127809	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	133,551	7,608,645	7,742,196	0.473744	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	10,080	245,616	255,696	1.921950	0.000000	92.00
200.00		Subtotal (see instructions)	9,110,850	45,534,878	54,645,728			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,110,850	45,534,878	54,645,728			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/21/2018 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
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
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501	SLEEP DISORDER	0.000000		75.01
76.00	03950	SENIOR RENEWAL CENTER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/21/2018 4:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	219,981	11,745,255	0.018729	360,332	6,749	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	100,164	1,684,781	0.059452	283	17	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	350,268	11,143,779	0.031432	151,682	4,768	54.00
60.00	06000	LABORATORY	80,364	9,731,789	0.008258	238,689	1,971	60.00
65.00	06500	RESPIRATORY THERAPY	38,903	660,447	0.058904	102,005	6,009	65.00
66.00	06600	PHYSICAL THERAPY	40,601	1,484,717	0.027346	67,987	1,859	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,192	144,989	0.022015	5,454	120	67.00
68.00	06800	SPEECH PATHOLOGY	1,591	847	1.878394	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	27,562	1,661,094	0.016593	98,119	1,628	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,117	1,515,401	0.009316	181,008	1,686	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,504	268,502	0.024223	46,288	1,121	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83,377	3,047,023	0.027363	419,224	11,471	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	13,557	67,327	0.201361	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	37,673	915,683	0.041142	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	4,363	324,540	0.013444	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	135,633	7,742,196	0.017519	366	6	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	36,420	255,696	0.142435	396	56	92.00
200.00		Total (lines 50 through 199)	1,194,270	52,394,066		1,671,833	37,461	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/21/2018 4:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/21/2018 4:45 pm

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	11,745,255	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,684,781	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,143,779	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,731,789	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	660,447	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,484,717	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	144,989	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	847	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,661,094	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,515,401	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	268,502	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,047,023	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	07501	SLEEP DISORDER	0	0	0	67,327	0.000000	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	915,683	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	324,540	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	7,742,196	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	255,696	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	52,394,066		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/21/2018 4:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	360,332	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	283	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	151,682	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	238,689	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	102,005	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	67,987	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	5,454	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	98,119	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	181,008	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	46,288	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	419,224	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0.000000	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	366	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	396	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,671,833	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/21/2018 4:45 pm

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	0.205261	0	2,896,261	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.882807	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184895	0	2,874,106	0	0	54.00
60.00	06000	LABORATORY	0.236004	0	2,337,144	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.188291	0	23,784	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.371960	0	362,695	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.099808	0	14,173	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8.485242	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.270518	0	511,451	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.192806	0	291,777	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.472131	0	59,333	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333916	0	498,756	5,687	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	1.062709	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.871566	0	694,072	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.127809	0	59,983	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.473744	0	1,855,072	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.921950	0	122,859	0	0	92.00
200.00		Subtotal (see instructions)		0	12,601,466	5,687	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	12,601,466	5,687	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/21/2018 4:45 pm

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	594,489	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	531,408	0		54.00
60.00	06000	LABORATORY	551,575	0		60.00
65.00	06500	RESPIRATORY THERAPY	28,262	0		65.00
66.00	06600	PHYSICAL THERAPY	134,908	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,415	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	138,357	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,256	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,013	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	166,543	1,899		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0		75.01
76.00	03950	SENIOR RENEWAL CENTER	604,930	0		76.00
76.97	07697	CARDIAC REHABILITATION	7,666	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	878,829	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	236,129	0		92.00
200.00		Subtotal (see instructions)	3,958,780	1,899		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,958,780	1,899		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1335 | Component CCN: 15-Z335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/21/2018 4:45 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.205261	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.882807	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184895	0	0	0	0	54.00
60.00	06000	LABORATORY	0.236004	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.188291	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.371960	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.099808	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8.485242	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.270518	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.192806	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.472131	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333916	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	1.062709	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.871566	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.127809	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.473744	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.921950	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: 15-1335 | Component CCN: 15-Z335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 11/21/2018 4:45 pm

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
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
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0		75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 11/21/2018 4:45 pm

Title XIX | Hospital | Cost

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,996	0.00	72	30.00
43.00	04300	NURSERY		0	621	0.00	26	43.00
200.00		Total (lines 30 through 199)		0	2,617		98	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/21/2018 4:45 pm

Title XIX | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/21/2018 4:45 pm

Title XIX | 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	11,745,255	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,684,781	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,143,779	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,731,789	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	660,447	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,484,717	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	144,989	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	847	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,661,094	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,515,401	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	268,502	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,047,023	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	07501	SLEEP DISORDER	0	0	0	67,327	0.000000	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	915,683	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	324,540	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	7,742,196	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	255,696	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	52,394,066		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/21/2018 4:45 pm

Title XIX | 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	72,569	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	115,216	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	27,311	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	46,975	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	24,063	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,248	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	6,050	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	23,185	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	46,444	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0.000000	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	22,197	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,546	0	0	0	92.00
200.00		Total (lines 50 through 199)		389,804	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/21/2018 4:45 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,221	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,996	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,675	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	112	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)	113	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)	744	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)	21	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)	147	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)	3,400,250	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)	344,464	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,055,786	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,055,786	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)	1,530.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,139,027	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,139,027	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/21/2018 4:45 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	529,849	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,668,876	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)	32,150	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	225,050	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	257,200	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)	321	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,530.95	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	491,435	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1335	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/21/2018 4:45 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	251,991	3,400,250	0.074110	491,435	36,420	90.00
91.00	Nursing School cost	0	3,400,250	0.000000	491,435	0	91.00
92.00	Allied health cost	0	3,400,250	0.000000	491,435	0	92.00
93.00	All other Medical Education	0	3,400,250	0.000000	491,435	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/21/2018 4:45 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,221	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,996	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,675	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	112	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)	113	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)	72	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)	621	15.00
16.00	Nursery days (title V or XIX only)	26	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)	3,400,250	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)	344,464	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,055,786	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,055,786	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)	1,530.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	110,228	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)	110,228	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/21/2018 4:45 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	599,324	621	965.10	26	25,093	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)	199,571	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	334,892	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)	321	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,530.95	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	491,435	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1335	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/21/2018 4:45 pm
	Title XIX	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	251,991	3,400,250	0.074110	491,435	36,420	90.00
91.00	Nursing School cost	0	3,400,250	0.000000	491,435	0	91.00
92.00	Allied health cost	0	3,400,250	0.000000	491,435	0	92.00
93.00	All other Medical Education	0	3,400,250	0.000000	491,435	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/21/2018 4:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		589,984		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.205261	360,332	73,962	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.882807	283	250	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184895	151,682	28,045	54.00
60.00	06000	LABORATORY	0.236004	238,689	56,332	60.00
65.00	06500	RESPIRATORY THERAPY	1.188291	102,005	121,212	65.00
66.00	06600	PHYSICAL THERAPY	0.371960	67,987	25,288	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.099808	5,454	544	67.00
68.00	06800	SPEECH PATHOLOGY	8.485242	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.270518	98,119	26,543	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.192806	181,008	34,899	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.472131	46,288	21,854	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333916	419,224	139,986	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	1.062709	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.871566	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.127809	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.473744	366	173	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.921950	396	761	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,671,833	529,849	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)		1,671,833		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1335 | Component CCN: 15-Z335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/21/2018 4:45 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.205261	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.882807	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184895	8,242	1,524	54.00
60.00	06000	LABORATORY	0.236004	21,468	5,067	60.00
65.00	06500	RESPIRATORY THERAPY	1.188291	12,169	14,460	65.00
66.00	06600	PHYSICAL THERAPY	0.371960	59,165	22,007	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.099808	26,879	2,683	67.00
68.00	06800	SPEECH PATHOLOGY	8.485242	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.270518	6,894	1,865	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.192806	7,095	1,368	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.472131	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333916	33,769	11,276	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	1.062709	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.871566	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.127809	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.473744	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.921950	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		175,681	60,250	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)		175,681		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/21/2018 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		33,694		30.00
43.00	04300	NURSERY		55,081		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.205261	72,569	14,896	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.882807	115,216	101,713	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184895	27,311	5,050	54.00
60.00	06000	LABORATORY	0.236004	46,975	11,086	60.00
65.00	06500	RESPIRATORY THERAPY	1.188291	24,063	28,594	65.00
66.00	06600	PHYSICAL THERAPY	0.371960	3,248	1,208	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.099808	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8.485242	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.270518	6,050	1,637	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.192806	23,185	4,470	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.472131	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333916	46,444	15,508	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	1.062709	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.871566	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.127809	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.473744	22,197	10,516	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.921950	2,546	4,893	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		389,804	199,571	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)		389,804		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1335	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/21/2018 4:45 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,960,679	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)	3,960,679	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)	4,000,286	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)	30,131	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,065,474	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)	1,904,681	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)	1,904,681	30.00
31.00	Primary payer payments	2,065	31.00
32.00	Subtotal (line 30 minus line 31)	1,902,616	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)	608,852	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	395,754	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	484,937	36.00
37.00	Subtotal (see instructions)	2,298,370	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)	2,298,370	40.00
40.01	Sequestration adjustment (see instructions)	45,967	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,115,398	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	137,005	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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2018 4:45 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,701,221		1,982,098	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	01/29/2018	64,000	01/29/2018	133,300	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)		64,000		133,300	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,765,221		2,115,398	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		137,005	6.01
6.02	SETTLEMENT TO PROGRAM		289,478		0	6.02
7.00	Total Medicare program liability (see instructions)		1,475,743		2,252,403	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: 15-1335 | Component CCN: 15-Z335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2018 4:45 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		339,016		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	04/20/2018	43,600		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)		43,600		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)		382,616		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		69,389		0	6.02
7.00	Total Medicare program liability (see instructions)		313,227		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1335	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/21/2018 4:45 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1335 Component CCN: 15-Z335	Period: From 07/01/2017 To 06/30/2018	Worksheet E-2 Date/Time Prepared: 11/21/2018 4:45 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	259,772	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)	60,853	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	168	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)	320,625	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	320,625	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)	320,625	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,843	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)	318,782	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)	1,288	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	837	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,288	0	18.00
19.00	Total (see instructions)	319,619	0	19.00
19.01	Sequestration adjustment (see instructions)	6,392	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	382,616	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)	-69,389	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: 15-1335	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Prepared: 11/21/2018 4:45 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,668,876	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)	1,668,876	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,685,565	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)	1,685,565	19.00
20.00	Deductibles (exclude professional component)	194,932	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,490,633	22.00
23.00	Coinsurance	2,339	23.00
24.00	Subtotal (line 22 minus line 23)	1,488,294	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	27,024	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	17,566	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	15,566	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,505,860	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)	1,505,860	30.00
30.01	Sequestration adjustment (see instructions)	30,117	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,765,221	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)	-289,478	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: 15-1335	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/21/2018 4:45 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	334,892		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)	334,892	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)	334,892	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	33,694		8.00
9.00	Ancillary service charges	389,804	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)	423,498	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)	423,498	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	88,606	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)	334,892	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)	334,892	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)	334,892	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)	334,892	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	334,892	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)	334,892	0	40.00
41.00	Interim payments	334,892	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: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/21/2018 4:45 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	34,197	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,980,706	0	0	0	4.00
5.00	Other receivable	589,658	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,404,021	0	0	0	6.00
7.00	Inventory	444,320	0	0	0	7.00
8.00	Prepaid expenses	4,074	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,648,934	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	100,000	0	0	0	12.00
13.00	Land improvements	83,405	0	0	0	13.00
14.00	Accumulated depreciation	-54,999	0	0	0	14.00
15.00	Buildings	6,739,028	0	0	0	15.00
16.00	Accumulated depreciation	-2,110,376	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,807,253	0	0	0	19.00
20.00	Accumulated depreciation	-1,379,774	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	3,965,267	0	0	0	23.00
24.00	Accumulated depreciation	-3,126,710	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)	7,023,094	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	59,127	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	59,127	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,731,155	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,283,520	0	0	0	37.00
38.00	Salaries, wages, and fees payable	420,018	0	0	0	38.00
39.00	Payroll taxes payable	90,907	0	0	0	39.00
40.00	Notes and loans payable (short term)	102,671	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	3,170,487	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,067,603	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,204,101	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)	7,204,101	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,271,704	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-2,540,549				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-2,540,549	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,731,155	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/21/2018 4:45 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-3,078,534		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-767,443				2.00
3.00	Total (sum of line 1 and line 2)		-3,845,977		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00	Rounding	0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-3,845,977		0		11.00
12.00	Transfer from Affiliates	-1,222,744		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00	Released Capital	-82,684		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		-1,305,428		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-2,540,549		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00	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			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00	Released Capital		0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/21/2018 4:45 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,337,847		4,337,847	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)	4,337,847		4,337,847	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,337,847		4,337,847	17.00
18.00	Ancillary services	4,311,607	35,183,303	39,494,910	18.00
19.00	Outpatient services	143,631	7,853,132	7,996,763	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 Operating Revenue	1,109,799	1,706,701	2,816,500	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,902,884	44,743,136	54,646,020	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,314,405		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)		20,314,405		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1335 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-3 | Date/Time Prepared: 11/21/2018 4:45 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	54,646,020	1.00
2.00	Less contractual allowances and discounts on patients' accounts	35,305,593	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,340,427	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,314,405	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-973,978	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	-1,672	6.00
7.00	Income from investments	1,454	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	65,320	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	5,042	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	17,473	22.00
23.00	Governmental appropriations	12,522	23.00
24.00	Other	5,757	24.00
24.01	Loss on Interest Rate Swaps	5,872	24.01
24.03	State Program Revenue	48,133	24.03
24.05	Foundation	25,234	24.05
24.06	Medical Staff Dues	21,400	24.06
25.00	Total other income (sum of lines 6-24)	206,535	25.00
26.00	Total (line 5 plus line 25)	-767,443	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-767,443	29.00