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: 15-1303	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/28/2018 9:26 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/28/2018 Time: 9:26 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT JENNINGS HOSPITAL (15-1303) 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	52,960	46,490	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	41,946	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	94,906	46,490	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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/27/2018 5:06 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 301 HENRY STREET	PO Box:			1.00
2.00	City: NORTH VERNON	State: IN	Zip Code: 47265	County: JENNINGS	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 JENNINGS HOSPITAL	151303	99915	1	07/01/1996	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT JENNINGS SWING BED	15Z303	99915		07/05/1991	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: 1.00	To: 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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2018 5:06 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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/27/2018 5:06 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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/27/2018 5:06 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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2018 5:06 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	Y	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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2018 5:06 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:	50,060	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	15HO46	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/27/2018 5:06 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: 46260	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	Y	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/27/2018 5:06 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/10/2018	Y	10/10/2018	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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 11/27/2018 5:06 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				Y	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.				Y	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.				Y	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: 15-1303	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/27/2018 5:06 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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 11/27/2018 5:06 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	14,952.00	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	14,952.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	14,952.00	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	88.00				0	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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/27/2018 5:06 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)	402	14	623			1.00
2.00	HMO and other (see instructions)	79	36				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	103	0	103			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	18			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	505	14	744			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)	505	14	744	0.00	56.71	14.00
15.00	CAH visits	10,060	942	36,122			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	0	0	0	0.00	0.00	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	56.71	27.00
28.00	Observation Bed Days		0	604			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/27/2018 5:06 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	128	7	212	1.00
2.00	HMO and other (see instructions)			30	15		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	128	7	212	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	0.00					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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/27/2018 5:06 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)	0.236609	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	137,492	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	18,650,446	6.00
7.00	Medicaid cost (line 1 times line 6)	4,412,863	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	4,275,371	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,275,371	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)	4,941,124	1,941,280	6,882,404	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,169,114	1,941,280	3,110,394	21.00
22.00	Payments received from patients for amounts previously written off as charity care	29,083	34,011	63,094	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,140,031	1,907,269	3,047,300	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)	1,358,559	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	599,463	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	922,250	27.01
28.00	Non-Medicare bad debt expense (see instructions)	436,309	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	426,022	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,473,322	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,748,693	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/27/2018 5:06 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		751,139	751,139	-4,537	746,602	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-44,487	1,476,247	1,431,760	0	1,431,760	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	593,171	3,362,393	3,955,564	4,537	3,960,101	5.00
7.00	00700	OPERATION OF PLANT	0	647,960	647,960	0	647,960	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	57,284	57,284	0	57,284	8.00
9.00	00900	HOUSEKEEPING	0	321,271	321,271	0	321,271	9.00
10.00	01000	DIETARY	0	260,715	260,715	-206,053	54,662	10.00
11.00	01100	CAFETERIA	0	0	0	206,053	206,053	11.00
13.00	01300	NURSING ADMINISTRATION	87,317	19,690	107,007	0	107,007	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,907	9,907	0	9,907	14.00
15.00	01500	PHARMACY	198,419	472,153	670,572	-84	670,488	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	333	333	0	333	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	820,441	100,102	920,543	-923	919,620	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	273,739	185,641	459,380	-24,526	434,854	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	629,382	838,686	1,468,068	-3,732	1,464,336	54.00
60.00	06000	LABORATORY	4,619	1,006,797	1,011,416	0	1,011,416	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	310,634	310,634	-41,721	268,913	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	41,721	41,721	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	21,222	21,222	31,155	52,377	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	18,180	18,180	0	18,180	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	ADULT MENTAL HEALTH	0	411,164	411,164	0	411,164	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	880,891	1,001,237	1,882,128	-1,890	1,880,238	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)	3,443,492	11,272,755	14,716,247	0	14,716,247	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NRCC	0	43,755	43,755	0	43,755	194.00
194.01	07951	SPN	0	0	0	0	0	194.01
194.02	07952	OUTPATIENT CLINICS	0	0	0	0	0	194.02
194.03	07953	MARKETING	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	3,443,492	11,316,510	14,760,002	0	14,760,002	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/27/2018 5:06 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	-128,225	618,377		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	22,036	1,453,796		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,235,069	5,195,170		5.00
7.00	00700	OPERATION OF PLANT	0	647,960		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	57,284		8.00
9.00	00900	HOUSEKEEPING	0	321,271		9.00
10.00	01000	DIETARY	1,100	55,762		10.00
11.00	01100	CAFETERIA	-96,694	109,359		11.00
13.00	01300	NURSING ADMINISTRATION	0	107,007		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,907		14.00
15.00	01500	PHARMACY	-3,851	666,637		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	333		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-811	918,809		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	434,854		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-3,866	1,460,470		54.00
60.00	06000	LABORATORY	-24,463	986,953		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	-12,128	256,785		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	41,721		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	52,377		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	18,180		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	ADULT MENTAL HEALTH	0	411,164		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	-150,000	1,730,238		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)	838,167	15,554,414		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NRCC	0	43,755		194.00
194.01	07951	SPN	0	0		194.01
194.02	07952	OUTPATIENT CLINICS	0	0		194.02
194.03	07953	MARKETING	65,794	65,794		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	903,961	15,663,963		200.00

RECLASSIFICATIONS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/27/2018 5:06 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	0	206,053		1.00
	TOTALS		0	206,053		
	B - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,537		1.00
	TOTALS		0	4,537		
	C - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		31,155		1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
			0	31,155		
	D - OCCUPATIONAL THERAPY RECLASS					
1.00	OCCUPATIONAL THERAPY	67.00	0	41,721		1.00
	TOTALS		0	41,721		
500.00	Grand Total: Increases		0	283,466		500.00

RECLASSIFICATIONS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/27/2018 5:06 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	206,053	0		1.00
	TOTALS		0	206,053			
	B - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,537	9		1.00
	TOTALS		0	4,537			
	C - MEDICAL SUPPLIES						
1.00	PHARMACY	15.00		84			1.00
2.00	ADULTS & PEDIATRICS	30.00		923			2.00
3.00	OPERATING ROOM	50.00		24,526			3.00
4.00	RADIOLOGY - DIAGNOSTIC	54.00		3,732			4.00
5.00	EMERGENCY	91.00		1,890			5.00
			0	31,155			
	D - OCCUPATIONAL THERAPY RECLASS						
1.00	PHYSICAL THERAPY	66.00	0	41,721	0		1.00
	TOTALS		0	41,721			
500.00	Grand Total: Decreases		0	283,466			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/27/2018 5:06 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	127,944	0	0	0	0	1.00
2.00	Land Improvements	409,779	10,500	0	10,500	0	2.00
3.00	Buildings and Fixtures	14,084,619	108,059	0	108,059	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,035,388	0	0	0	0	5.00
6.00	Movable Equipment	4,234,637	467,446	0	467,446	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,892,367	586,005	0	586,005	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	19,892,367	586,005	0	586,005	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	127,944	0	1.00
2.00	Land Improvements	420,279	0	2.00
3.00	Buildings and Fixtures	14,192,678	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,035,388	0	5.00
6.00	Movable Equipment	4,702,083	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,478,372	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	20,478,372	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 11/27/2018 5:06 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	369,274	0	366,900	14,965	0	1.00
3.00	Total (sum of lines 1-2)	369,274	0	366,900	14,965	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	751,139		1.00
3.00	Total (sum of lines 1-2)	0	751,139		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/27/2018 5:06 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	20,478,373	0	20,478,373	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	20,478,373	0	20,478,373	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	364,737	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	364,737	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	238,675	14,965	0	0	618,377	1.00
3.00	Total (sum of lines 1-2)	238,675	14,965	0	0	618,377	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/27/2018 5:06 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	-128,225	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-1,606	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	-178,329			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	1,976,341			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-96,694	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	-12,128	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	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	CHARITABLE EXPENSE	A	-1,190	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/27/2018 5:06 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	PROVIDER TAX ADJUSTMENT	B	-650,813	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	ADMINISTRATIVE ADVERTISING	A	-3,948	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ENTERTAINMENT	A	-312	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PROMOTIONAL ITEMS	A	-811	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	PAYROLL INCENTIVE	A	25,058	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06	LOBBYING	A	-312	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MISC REVENUE	B	-3,851	PHARMACY	15.00	0	33.07
33.08	MISC REVENUE	B	1,100	DIETARY	10.00	0	33.08
33.09	MISC REVENUE	B	-17,297	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	MISC REVENUE	B	-3,022	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		903,961				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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/27/2018 5:06 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	231,694	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	4,357,678	2,678,825	2.00
3.00	194.03	MARKETING	HOME OFFICE - MARKETING	65,794	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	127,307	127,307	3.01
3.02	13.00	NURSING ADMINISTRATION	SVH CHARGEBACKS	420	420	3.02
3.03	15.00	PHARMACY	SVH CHARGEBACKS	24,000	24,000	3.03
3.04	50.00	OPERATING ROOM	SVH CHARGEBACKS	14	14	3.04
3.05	54.00	RADIOLOGY - DIAGNOSTIC	SVH CHARGEBACKS	38,555	38,555	3.05
3.06	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	366,900	366,900	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.			5,212,362	3,236,021	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: 15-1303	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-1 Date/Time Prepared: 11/27/2018 5:06 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	231,694	0		1.00
2.00	1,678,853	0		2.00
3.00	65,794	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	0		3.05
3.06	0	11		3.06
4.00	0	0		4.00
5.00	1,976,341			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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/27/2018 5:06 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	54.00	RADIOLOGY - DIAGNOSTIC	3,866	3,866	0	0	0	1.00
2.00	60.00	LABORATORY	24,463	24,463	0	0	0	2.00
3.00	91.00	EMERGENCY	150,000	150,000	0	0	0	3.00
4.00	91.00	EMERGENCY	672,618	0	672,618	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			850,947	178,329	672,618		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	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	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	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	3,866		1.00
2.00	60.00	LABORATORY	0	0	0	24,463		2.00
3.00	91.00	EMERGENCY	0	0	0	150,000		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	178,329		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2018 5:06 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					196	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)					54	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	0.00	1,576.00	1,753.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.87	53.21	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	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)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					129,027	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					93,277	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					222,304	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					222,304	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)					222,304	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)					8,024	24.00
25.00	Assistants (line 4 times column 3, line 11)					1,437	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,461	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)					2,393	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					11,854	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					11,854	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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/27/2018 5:06 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	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	222,304		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	11,854		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)	234,158		63.00
64.00	Total cost of outside supplier services (from your records)	246,286		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	12,128		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	9,461		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,393		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	11,854		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	2,393		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	2,393		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1303	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2018 5:06 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		48	1.00
2.00	Line 1 multiplied by 15 hours per week		720	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		96	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	0.00	564.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.61	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.81	38.81	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	43,772	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	43,772	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	43,772	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)	77.61	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	55,879	22.00
23.00	Total salary equivalency (see instructions)	55,879	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)	3,726	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)	3,726	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)	919	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	4,645	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)	4,645	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/27/2018 5:06 pm

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.61	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	55,879	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	4,645	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)	60,524	63.00
64.00	Total cost of outside supplier services (from your records)	41,721	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	3,726	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	919	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	4,645	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	919	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	919	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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/27/2018 5:06 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	618,377	618,377				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,453,796	0	1,453,796			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,195,170	54,630	247,235	5,497,035	5,497,035	5.00
7.00	00700	OPERATION OF PLANT	647,960	56,451	0	704,411	380,860	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	57,284	672	0	57,956	31,336	8.00
9.00	00900	HOUSEKEEPING	321,271	12,692	0	333,963	180,566	9.00
10.00	01000	DIETARY	55,762	6,258	0	62,020	33,533	10.00
11.00	01100	CAFETERIA	109,359	12,895	0	122,254	66,100	11.00
13.00	01300	NURSING ADMINISTRATION	107,007	1,467	36,394	144,868	78,327	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,907	10,288	0	20,195	10,919	14.00
15.00	01500	PHARMACY	666,637	5,789	82,701	755,127	408,281	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	333	48,973	0	49,306	26,659	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	918,809	58,015	341,961	1,318,785	713,038	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	434,854	46,101	114,095	595,050	321,730	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,460,470	37,360	262,328	1,760,158	951,679	54.00
60.00	06000	LABORATORY	986,953	15,582	1,925	1,004,460	543,089	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	256,785	21,946	0	278,731	150,704	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,721	0	0	41,721	22,558	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	52,377	0	0	52,377	28,319	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	18,180	0	0	18,180	9,830	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	ADULT MENTAL HEALTH	411,164	0	0	411,164	222,307	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	1,730,238	37,316	367,157	2,134,711	1,154,191	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)	15,554,414	426,435	1,453,796	15,362,472	5,334,026	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,199	0	3,199	1,730	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NRCC	43,755	0	0	43,755	23,657	194.00
194.01	07951	SPN	0	122,985	0	122,985	66,495	194.01
194.02	07952	OUTPATIENT CLINICS	0	65,758	0	65,758	35,554	194.02
194.03	07953	MARKETING	65,794	0	0	65,794	35,573	194.03
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)	15,663,963	618,377	1,453,796	15,663,963	5,497,035	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/27/2018 5:06 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,085,271					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,437	90,729				8.00
9.00	00900	HOUSEKEEPING	27,152	0	541,681			9.00
10.00	01000	DIETARY	13,387	0	46,839	155,779		10.00
11.00	01100	CAFETERIA	27,587	0	0	0	215,941	11.00
13.00	01300	NURSING ADMINISTRATION	3,139	0	0	0	4,694	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22,009	0	0	0	0	14.00
15.00	01500	PHARMACY	12,385	0	17,083	0	9,389	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	104,770	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	124,113	17,582	41,329	155,779	56,332	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	98,625	33,071	154,293	0	28,166	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	79,925	14,066	32,512	0	46,944	54.00
60.00	06000	LABORATORY	33,335	0	23,144	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	46,949	7,543	15,980	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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	ADULT MENTAL HEALTH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	79,830	14,066	119,027	0	70,416	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)	674,643	86,328	450,207	155,779	215,941	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	6,845	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NRCC	0	0	91,474	0	0	194.00
194.01	07951	SPN	263,106	0	0	0	0	194.01
194.02	07952	OUTPATIENT CLINICS	140,677	4,401	0	0	0	194.02
194.03	07953	MARKETING	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,085,271	90,729	541,681	155,779	215,941	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/27/2018 5:06 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	231,028					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	53,123				14.00
15.00	01500	PHARMACY	0	7	1,202,272			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	180,735		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	96,153	5,161	0	6,224	2,534,496	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	96,152	12,541	0	15,316	1,354,944	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	4,373	0	47,729	2,937,386	54.00
60.00	06000	LABORATORY	0	0	0	43,848	1,647,876	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	464	464	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,524	504,431	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	608	64,887	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	56	56	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,577	0	0	89,273	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	3,602	0	0	31,612	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,202,272	0	1,202,272	73.00
76.00	03950	ADULT MENTAL HEALTH	0	0	0	3,650	637,121	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	38,723	18,862	0	58,316	3,688,142	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)	231,028	53,123	1,202,272	180,735	14,692,960	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	11,774	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	158,886	194.00
194.01	07951	SPN	0	0	0	0	452,586	194.01
194.02	07952	OUTPATIENT CLINICS	0	0	0	0	246,390	194.02
194.03	07953	MARKETING	0	0	0	0	101,367	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	231,028	53,123	1,202,272	180,735	15,663,963	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/27/2018 5:06 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,534,496		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,354,944		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	2,937,386		54.00
60.00	06000	LABORATORY	0	1,647,876		60.00
65.00	06500	RESPIRATORY THERAPY	0	464		65.00
66.00	06600	PHYSICAL THERAPY	0	504,431		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	64,887		67.00
68.00	06800	SPEECH PATHOLOGY	0	56		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	89,273		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	31,612		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,202,272		73.00
76.00	03950	ADULT MENTAL HEALTH	0	637,121		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	3,688,142		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)	0	14,692,960		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	11,774		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NRCC	0	158,886		194.00
194.01	07951	SPN	0	452,586		194.01
194.02	07952	OUTPATIENT CLINICS	0	246,390		194.02
194.03	07953	MARKETING	0	101,367		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	15,663,963		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/27/2018 5:06 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	241,277	54,630	295,907	0	295,907	5.00
7.00	00700	OPERATION OF PLANT	2,583	56,451	59,034	0	20,502	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	672	672	0	1,687	8.00
9.00	00900	HOUSEKEEPING	1,245	12,692	13,937	0	9,720	9.00
10.00	01000	DIETARY	913	6,258	7,171	0	1,805	10.00
11.00	01100	CAFETERIA	0	12,895	12,895	0	3,558	11.00
13.00	01300	NURSING ADMINISTRATION	3,081	1,467	4,548	0	4,216	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,288	10,288	0	588	14.00
15.00	01500	PHARMACY	27,686	5,789	33,475	0	21,978	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	48,973	48,973	0	1,435	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,512	58,015	112,527	0	38,383	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	74,180	46,101	120,281	0	17,319	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	516,895	37,360	554,255	0	51,229	54.00
60.00	06000	LABORATORY	2,135	15,582	17,717	0	29,235	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,524	21,946	23,470	0	8,112	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,214	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	10,048	0	10,048	0	1,524	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	529	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	ADULT MENTAL HEALTH	794	0	794	0	11,967	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	26,067	37,316	63,383	0	62,132	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)	962,940	426,435	1,389,375	0	287,133	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,199	3,199	0	93	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	1,273	194.00
194.01	07951	SPN	0	122,985	122,985	0	3,579	194.01
194.02	07952	OUTPATIENT CLINICS	0	65,758	65,758	0	1,914	194.02
194.03	07953	MARKETING	0	0	0	0	1,915	194.03
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)	962,940	618,377	1,581,317	0	295,907	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/27/2018 5:06 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	79,536					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	105	2,464				8.00
9.00	00900	HOUSEKEEPING	1,990	0	25,647			9.00
10.00	01000	DIETARY	981	0	2,218	12,175		10.00
11.00	01100	CAFETERIA	2,022	0	0	0	18,475	11.00
13.00	01300	NURSING ADMINISTRATION	230	0	0	0	402	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,613	0	0	0	0	14.00
15.00	01500	PHARMACY	908	0	809	0	803	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,678	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,096	478	1,957	12,175	4,820	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,228	897	7,304	0	2,410	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	5,857	382	1,539	0	4,016	54.00
60.00	06000	LABORATORY	2,443	0	1,096	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,441	205	757	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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	ADULT MENTAL HEALTH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	5,850	382	5,636	0	6,024	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)	49,442	2,344	21,316	12,175	18,475	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	502	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NRCC	0	0	4,331	0	0	194.00
194.01	07951	SPN	19,282	0	0	0	0	194.01
194.02	07952	OUTPATIENT CLINICS	10,310	120	0	0	0	194.02
194.03	07953	MARKETING	0	0	0	0	0	194.03
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)	79,536	2,464	25,647	12,175	18,475	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/27/2018 5:06 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	9,396					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,489				14.00
15.00	01500	PHARMACY	0	2	57,975			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	58,086		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,910	1,213	0	2,000	186,559	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,911	2,948	0	4,922	167,220	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	1,028	0	15,338	633,644	54.00
60.00	06000	LABORATORY	0	0	0	14,091	64,582	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	149	149	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,454	37,439	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	195	1,409	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	18	18	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,016	0	0	13,588	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	847	0	0	1,376	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	57,975	0	57,975	73.00
76.00	03950	ADULT MENTAL HEALTH	0	0	0	1,173	13,934	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	1,575	4,435	0	18,746	168,163	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)	9,396	12,489	57,975	58,086	1,346,056	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	3,794	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	5,604	194.00
194.01	07951	SPN	0	0	0	0	145,846	194.01
194.02	07952	OUTPATIENT CLINICS	0	0	0	0	78,102	194.02
194.03	07953	MARKETING	0	0	0	0	1,915	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,396	12,489	57,975	58,086	1,581,317	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/27/2018 5:06 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	186,559		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	167,220		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	633,644		54.00
60.00	06000	LABORATORY	0	64,582		60.00
65.00	06500	RESPIRATORY THERAPY	0	149		65.00
66.00	06600	PHYSICAL THERAPY	0	37,439		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,409		67.00
68.00	06800	SPEECH PATHOLOGY	0	18		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,588		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	1,376		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	57,975		73.00
76.00	03950	ADULT MENTAL HEALTH	0	13,934		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	168,163		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)	0	1,346,056		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,794		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NRCC	0	5,604		194.00
194.01	07951	SPN	0	145,846		194.01
194.02	07952	OUTPATIENT CLINICS	0	78,102		194.02
194.03	07953	MARKETING	0	1,915		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,581,317		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/27/2018 5:06 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	69,965					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,487,979				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,181	593,171	-5,497,035	10,166,928		5.00
7.00	00700	OPERATION OF PLANT	6,387	0	0	704,411	57,397	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	76	0	0	57,956	76	8.00
9.00	00900	HOUSEKEEPING	1,436	0	0	333,963	1,436	9.00
10.00	01000	DIETARY	708	0	0	62,020	708	10.00
11.00	01100	CAFETERIA	1,459	0	0	122,254	1,459	11.00
13.00	01300	NURSING ADMINISTRATION	166	87,317	0	144,868	166	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,164	0	0	20,195	1,164	14.00
15.00	01500	PHARMACY	655	198,419	0	755,127	655	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,541	0	0	49,306	5,541	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,564	820,441	0	1,318,785	6,564	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,216	273,739	0	595,050	5,216	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	4,227	629,382	0	1,760,158	4,227	54.00
60.00	06000	LABORATORY	1,763	4,619	0	1,004,460	1,763	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,483	0	0	278,731	2,483	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	41,721	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	52,377	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	18,180	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	ADULT MENTAL HEALTH	0	0	0	411,164	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	4,222	880,891	0	2,134,711	4,222	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)	48,248	3,487,979	-5,497,035	9,865,437	35,680	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	362	0	0	3,199	362	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	43,755	0	194.00
194.01	07951	SPN	13,915	0	0	122,985	13,915	194.01
194.02	07952	OUTPATIENT CLINICS	7,440	0	0	65,758	7,440	194.02
194.03	07953	MARKETING	0	0	0	65,794	0	194.03
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)	618,377	1,453,796		5,497,035	1,085,271	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.838376	0.416802		0.540678	18.908149	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		0		295,907	79,536	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000000		0.029105	1.385717	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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/27/2018 5:06 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (ITEMIZED BILLS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,899					8.00
9.00	00900	HOUSEKEEPING	0	983				9.00
10.00	01000	DIETARY	0	85	9,125			10.00
11.00	01100	CAFETERIA	0	0	0	46		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1	1,939	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	31	0	2	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,701	75	9,125	12	807	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,365	280	0	6	807	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	6,961	59	0	10	0	54.00
60.00	06000	LABORATORY	0	42	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,733	29	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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	ADULT MENTAL HEALTH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	6,961	216	0	15	325	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)	42,721	817	9,125	46	1,939	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NRCC	0	166	0	0	0	194.00
194.01	07951	SPN	0	0	0	0	0	194.01
194.02	07952	OUTPATIENT CLINICS	2,178	0	0	0	0	194.02
194.03	07953	MARKETING	0	0	0	0	0	194.03
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)	90,729	541,681	155,779	215,941	231,028	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.020735	551.048830	17.071671	4,694.369565	119.148014	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,464	25,647	12,175	18,475	9,396	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.054879	26.090539	1.334247	401.630435	4.845797	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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/27/2018 5:06 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	268,097				14.00
15.00	01500	PHARMACY	37	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	57,449,152		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	26,045	0	1,978,507		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	63,289	0	4,868,507		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	22,070	0	15,171,230		54.00
60.00	06000	LABORATORY	0	0	13,937,790		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	147,395		65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,437,877		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	193,334		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	17,847		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,286	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	18,180	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0		73.00
76.00	03950	ADULT MENTAL HEALTH	0	0	1,160,196		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	95,190	0	18,536,469		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)	268,097	100	57,449,152		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	OTHER NRCC	0	0	0		194.00
194.01	07951	SPN	0	0	0		194.01
194.02	07952	OUTPATIENT CLINICS	0	0	0		194.02
194.03	07953	MARKETING	0	0	0		194.03
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)	53,123	1,202,272	180,735		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.198148	12,022.720000	0.003146		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,489	57,975	58,086		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.046584	579.750000	0.001011		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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/27/2018 5:06 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	2,534,496		2,534,496	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,354,944		1,354,944	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,937,386		2,937,386	0	0	54.00
60.00	06000	LABORATORY	1,647,876		1,647,876	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	464	0	464	0	0	65.00
66.00	06600	PHYSICAL THERAPY	504,431	0	504,431	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	64,887	0	64,887	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	56	0	56	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	89,273		89,273	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	31,612		31,612	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,202,272		1,202,272	0	0	73.00
76.00	03950	ADULT MENTAL HEALTH	637,121		637,121	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
91.00	09100	EMERGENCY	3,688,142		3,688,142	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,149,883		1,149,883		0	92.00
200.00		Subtotal (see instructions)	15,842,843	0	15,842,843	0	0	200.00
201.00		Less Observation Beds	1,149,883		1,149,883		0	201.00
202.00		Total (see instructions)	14,692,960	0	14,692,960	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/27/2018 5:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,217,591		1,217,591			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,862	4,856,645	4,868,507	0.278308	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	249,095	14,922,136	15,171,231	0.193616	0.000000	54.00
60.00	06000	LABORATORY	486,615	13,451,175	13,937,790	0.118231	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	102,836	44,559	147,395	0.003148	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	63,378	1,384,838	1,448,216	0.348312	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,364	182,970	193,334	0.335621	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	378	7,130	7,508	0.007459	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	144,237	584,292	728,529	0.122539	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	65,777	65,777	0.480594	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	462,162	3,392,313	3,854,475	0.311916	0.000000	73.00
76.00	03950	ADULT MENTAL HEALTH	0	1,160,196	1,160,196	0.549149	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
91.00	09100	EMERGENCY	106,667	18,429,802	18,536,469	0.198967	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	117,571	643,345	760,916	1.511183	0.000000	92.00
200.00		Subtotal (see instructions)	2,972,756	59,125,178	62,097,934			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,972,756	59,125,178	62,097,934			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/27/2018 5:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	ADULT MENTAL HEALTH	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/27/2018 5:06 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,534,496		2,534,496	0	2,534,496	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,354,944		1,354,944	0	1,354,944	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,937,386		2,937,386	0	2,937,386	54.00
60.00	06000	LABORATORY	1,647,876		1,647,876	0	1,647,876	60.00
65.00	06500	RESPIRATORY THERAPY	464	0	464	0	464	65.00
66.00	06600	PHYSICAL THERAPY	504,431	12,128	516,559	0	516,559	66.00
67.00	06700	OCCUPATIONAL THERAPY	64,887	0	64,887	0	64,887	67.00
68.00	06800	SPEECH PATHOLOGY	56	0	56	0	56	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	89,273		89,273	0	89,273	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	31,612		31,612	0	31,612	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,202,272		1,202,272	0	1,202,272	73.00
76.00	03950	ADULT MENTAL HEALTH	637,121		637,121	0	637,121	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
91.00	09100	EMERGENCY	3,688,142		3,688,142	0	3,688,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,149,883		1,149,883		1,149,883	92.00
200.00		Subtotal (see instructions)	15,842,843	0	15,854,971	0	15,854,971	200.00
201.00		Less Observation Beds	1,149,883		1,149,883		1,149,883	201.00
202.00		Total (see instructions)	14,692,960	0	14,705,088	0	14,705,088	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/27/2018 5:06 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,217,591		1,217,591			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,862	4,856,645	4,868,507	0.278308	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	249,095	14,922,136	15,171,231	0.193616	0.000000	54.00
60.00	06000	LABORATORY	486,615	13,451,175	13,937,790	0.118231	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	102,836	44,559	147,395	0.003148	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	63,378	1,384,838	1,448,216	0.348312	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,364	182,970	193,334	0.335621	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	378	7,130	7,508	0.007459	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	144,237	584,292	728,529	0.122539	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	65,777	65,777	0.480594	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	462,162	3,392,313	3,854,475	0.311916	0.000000	73.00
76.00	03950	ADULT MENTAL HEALTH	0	1,160,196	1,160,196	0.549149	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
91.00	09100	EMERGENCY	106,667	18,429,802	18,536,469	0.198967	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	117,571	643,345	760,916	1.511183	0.000000	92.00
200.00		Subtotal (see instructions)	2,972,756	59,125,178	62,097,934			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,972,756	59,125,178	62,097,934			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/27/2018 5:06 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.278308	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.193616	54.00
60.00	06000	LABORATORY	0.118231	60.00
65.00	06500	RESPIRATORY THERAPY	0.003148	65.00
66.00	06600	PHYSICAL THERAPY	0.356686	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.335621	67.00
68.00	06800	SPEECH PATHOLOGY	0.007459	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.122539	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.480594	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.311916	73.00
76.00	03950	ADULT MENTAL HEALTH	0.549149	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
91.00	09100	EMERGENCY	0.198967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.511183	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part II Date/Time Prepared: 11/27/2018 5:06 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,354,944	167,220	1,187,724	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,937,386	633,644	2,303,742	0	0	54.00
60.00	06000	LABORATORY	1,647,876	64,582	1,583,294	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	464	149	315	0	0	65.00
66.00	06600	PHYSICAL THERAPY	504,431	37,439	466,992	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	64,887	1,409	63,478	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	56	18	38	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	89,273	13,588	75,685	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	31,612	1,376	30,236	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,202,272	57,975	1,144,297	0	0	73.00
76.00	03950	ADULT MENTAL HEALTH	637,121	13,934	623,187	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	3,688,142	168,163	3,519,979	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,149,883	84,641	1,065,242	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	13,308,347	1,244,138	12,064,209	0	0	200.00
201.00		Less Observation Beds	1,149,883	84,641	1,065,242	0	0	201.00
202.00		Total (line 200 minus line 201)	12,158,464	1,159,497	10,998,967	0	0	202.00

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

Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part II Date/Time Prepared: 11/27/2018 5:06 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,354,944	4,868,507	0.278308		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,937,386	15,171,231	0.193616		54.00
60.00	06000	LABORATORY	1,647,876	13,937,790	0.118231		60.00
65.00	06500	RESPIRATORY THERAPY	464	147,395	0.003148		65.00
66.00	06600	PHYSICAL THERAPY	504,431	1,448,216	0.348312		66.00
67.00	06700	OCCUPATIONAL THERAPY	64,887	193,334	0.335621		67.00
68.00	06800	SPEECH PATHOLOGY	56	7,508	0.007459		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	89,273	728,529	0.122539		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	31,612	65,777	0.480594		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,202,272	3,854,475	0.311916		73.00
76.00	03950	ADULT MENTAL HEALTH	637,121	1,160,196	0.549149		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000		88.00
91.00	09100	EMERGENCY	3,688,142	18,536,469	0.198967		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,149,883	760,916	1.511183		92.00
200.00		Subtotal (sum of lines 50 thru 199)	13,308,347	60,880,343			200.00
201.00		Less Observation Beds	1,149,883	0			201.00
202.00		Total (line 200 minus line 201)	12,158,464	60,880,343			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/27/2018 5:06 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	167,220	4,868,507	0.034347	1,284	44	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	633,644	15,171,231	0.041766	61,060	2,550	54.00
60.00	06000	LABORATORY	64,582	13,937,790	0.004634	296,060	1,372	60.00
65.00	06500	RESPIRATORY THERAPY	149	147,395	0.001011	54,604	55	65.00
66.00	06600	PHYSICAL THERAPY	37,439	1,448,216	0.025852	23,061	596	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,409	193,334	0.007288	2,955	22	67.00
68.00	06800	SPEECH PATHOLOGY	18	7,508	0.002397	378	1	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,588	728,529	0.018651	65,719	1,226	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,376	65,777	0.020919	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,975	3,854,475	0.015041	325,156	4,891	73.00
76.00	03950	ADULT MENTAL HEALTH	13,934	1,160,196	0.012010	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
91.00	09100	EMERGENCY	168,163	18,536,469	0.009072	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	84,641	760,916	0.111236	6,445	717	92.00
200.00		Total (lines 50 through 199)	1,244,138	60,880,343		836,722	11,474	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/27/2018 5:06 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
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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	ADULT MENTAL HEALTH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/27/2018 5:06 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	4,868,507	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	15,171,231	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	13,937,790	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	147,395	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,448,216	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	193,334	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7,508	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	728,529	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	65,777	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,854,475	0.000000	73.00
76.00	03950	ADULT MENTAL HEALTH	0	0	0	1,160,196	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	18,536,469	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	760,916	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	60,880,343		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/27/2018 5:06 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	1,284	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	61,060	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	296,060	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	54,604	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	23,061	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,955	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	378	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	65,719	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	325,156	0	0	0	73.00
76.00	03950	ADULT MENTAL HEALTH	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	6,445	0	0	0	92.00
200.00		Total (lines 50 through 199)		836,722	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/27/2018 5:06 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	0.278308	0	1,044,894	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.193616	0	3,486,810	0	0	54.00
60.00	06000	LABORATORY	0.118231	0	4,158,863	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.003148	0	14,536	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.348312	0	317,365	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.335621	0	43,425	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.007459	0	1,804	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.122539	0	143,931	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.480594	0	18,786	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.311916	0	1,252,756	2,852	0	73.00
76.00	03950	ADULT MENTAL HEALTH	0.549149	0	1,109,952	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.198967	0	3,620,768	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.511183	0	277,146	0	0	92.00
200.00		Subtotal (see instructions)		0	15,491,036	2,852	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	15,491,036	2,852	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/27/2018 5:06 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	290,802	0		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	675,102	0		54.00
60.00	06000	LABORATORY	491,707	0		60.00
65.00	06500	RESPIRATORY THERAPY	46	0		65.00
66.00	06600	PHYSICAL THERAPY	110,542	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	14,574	0		67.00
68.00	06800	SPEECH PATHOLOGY	13	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,637	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	9,028	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	390,755	890		73.00
76.00	03950	ADULT MENTAL HEALTH	609,529	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	720,413	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	418,818	0		92.00
200.00		Subtotal (see instructions)	3,748,966	890		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,748,966	890		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1303 | Component CCN: 15-Z303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/27/2018 5:06 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	0.278308	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.193616	0	0	0	0	54.00
60.00	06000	LABORATORY	0.118231	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.003148	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.348312	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.335621	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.007459	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.122539	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.480594	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.311916	0	0	0	0	73.00
76.00	03950	ADULT MENTAL HEALTH	0.549149	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.198967	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.511183	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: 15-1303 | Component CCN: 15-Z303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 11/27/2018 5:06 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
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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	ADULT MENTAL HEALTH	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
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 CAPITAL COSTS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part I Date/Time Prepared: 11/27/2018 5:06 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	186,559	14,616	171,943	1,227	140.13	30.00
200.00	Total (lines 30 through 199)	186,559		171,943	1,227		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	14	1,962	30.00
200.00	Total (lines 30 through 199)	14	1,962	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/27/2018 5:06 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	167,220	4,868,507	0.034347	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	633,644	15,171,231	0.041766	11,802	493	54.00
60.00	06000	LABORATORY	64,582	13,937,790	0.004634	17,713	82	60.00
65.00	06500	RESPIRATORY THERAPY	149	147,395	0.001011	0	0	65.00
66.00	06600	PHYSICAL THERAPY	37,439	1,448,216	0.025852	3,166	82	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,409	193,334	0.007288	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18	7,508	0.002397	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,588	728,529	0.018651	1,166	22	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,376	65,777	0.020919	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,975	3,854,475	0.015041	18,133	273	73.00
76.00	03950	ADULT MENTAL HEALTH	13,934	1,160,196	0.012010	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
91.00	09100	EMERGENCY	168,163	18,536,469	0.009072	14,597	132	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	84,641	760,916	0.111236	13,832	1,539	92.00
200.00		Total (lines 50 through 199)	1,244,138	60,880,343		80,409	2,623	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 11/27/2018 5:06 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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	1,227	0.00	14	30.00
200.00		Total (lines 30 through 199)		0	1,227		14	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/27/2018 5:06 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	ADULT MENTAL HEALTH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/27/2018 5:06 pm

Title XIX | Hospital | PPS

		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	4,868,507	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	15,171,231	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	13,937,790	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	147,395	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,448,216	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	193,334	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7,508	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	728,529	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	65,777	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,854,475	0.000000	73.00
76.00	03950	ADULT MENTAL HEALTH	0	0	0	1,160,196	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	18,536,469	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	760,916	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	60,880,343		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/27/2018 5:06 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	11,802	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	17,713	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,166	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	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,166	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	18,133	0	0	0	73.00
76.00	03950	ADULT MENTAL HEALTH	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	14,597	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	13,832	0	0	0	92.00
200.00		Total (lines 50 through 199)		80,409	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1303	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/27/2018 5:06 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)	1,348	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,227	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)	623	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	51	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)	52	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	9	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)	9	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	402	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)	51	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)	52	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,534,496	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	1,236	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)	1,236	25.00
26.00	Total swing-bed cost (see instructions)	198,561	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,335,935	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,335,935	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)	1,903.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	765,320	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)	765,320	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/27/2018 5:06 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	175,595	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	940,915	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)	97,093	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	98,997	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	196,090	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)	604	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,903.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,149,883	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1303	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/27/2018 5:06 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	186,559	2,534,496	0.073608	1,149,883	84,641	90.00
91.00	Nursing School cost	0	2,534,496	0.000000	1,149,883	0	91.00
92.00	Allied health cost	0	2,534,496	0.000000	1,149,883	0	92.00
93.00	All other Medical Education	0	2,534,496	0.000000	1,149,883	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1303	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/27/2018 5:06 pm
	Title XIX	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,348	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,227	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)	623	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	51	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)	52	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	9	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)	9	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	14	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,534,496	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	1,236	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)	1,236	25.00
26.00	Total swing-bed cost (see instructions)	198,561	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,335,935	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,335,935	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)	1,903.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	26,653	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)	26,653	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/27/2018 5:06 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	35,114	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	61,767	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)	1,962	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,623	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	4,585	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	57,182	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)	604	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,903.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,149,883	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1303	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/27/2018 5:06 pm
	Title XIX	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	186,559	2,534,496	0.073608	1,149,883	84,641	90.00
91.00	Nursing School cost	0	2,534,496	0.000000	1,149,883	0	91.00
92.00	Allied health cost	0	2,534,496	0.000000	1,149,883	0	92.00
93.00	All other Medical Education	0	2,534,496	0.000000	1,149,883	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1303	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/27/2018 5:06 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		479,759		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.278308	1,284	357	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.193616	61,060	11,822	54.00
60.00	06000	LABORATORY	0.118231	296,060	35,003	60.00
65.00	06500	RESPIRATORY THERAPY	0.003148	54,604	172	65.00
66.00	06600	PHYSICAL THERAPY	0.348312	23,061	8,032	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.335621	2,955	992	67.00
68.00	06800	SPEECH PATHOLOGY	0.007459	378	3	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.122539	65,719	8,053	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.480594	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.311916	325,156	101,421	73.00
76.00	03950	ADULT MENTAL HEALTH	0.549149	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.198967	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.511183	6,445	9,740	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		836,722	175,595	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)		836,722		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1303 | Component CCN: 15-Z303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/27/2018 5:06 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.278308	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.193616	11,049	2,139	54.00
60.00	06000	LABORATORY	0.118231	30,868	3,650	60.00
65.00	06500	RESPIRATORY THERAPY	0.003148	11,261	35	65.00
66.00	06600	PHYSICAL THERAPY	0.348312	25,590	8,913	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.335621	4,988	1,674	67.00
68.00	06800	SPEECH PATHOLOGY	0.007459	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.122539	10,894	1,335	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.480594	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.311916	34,940	10,898	73.00
76.00	03950	ADULT MENTAL HEALTH	0.549149	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.198967	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.511183	1,818	2,747	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		131,408	31,391	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)		131,408		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/27/2018 5:06 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		49,691		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.278308	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.193616	11,802	2,285	54.00
60.00	06000	LABORATORY	0.118231	17,713	2,094	60.00
65.00	06500	RESPIRATORY THERAPY	0.003148	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.356686	3,166	1,129	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.335621	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.007459	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.122539	1,166	143	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.480594	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.311916	18,133	5,656	73.00
76.00	03950	ADULT MENTAL HEALTH	0.549149	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
91.00	09100	EMERGENCY	0.198967	14,597	2,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.511183	13,832	20,903	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		80,409	35,114	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)		80,409		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1303	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/27/2018 5:06 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,749,856	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)	3,749,856	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)	3,787,355	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)	35,637	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,379,777	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)	1,371,941	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)	1,371,941	30.00
31.00	Primary payer payments	204	31.00
32.00	Subtotal (line 30 minus line 31)	1,371,737	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)	902,058	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	586,338	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	667,658	36.00
37.00	Subtotal (see instructions)	1,958,075	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)	1,958,075	40.00
40.01	Sequestration adjustment (see instructions)	39,162	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,872,423	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	46,490	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: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 11/27/2018 5:06 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		715,993		1,792,923	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	01/24/2018	43,300	01/24/2018	79,500	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)		43,300		79,500	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)		759,293		1,872,423	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		52,960		46,490	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		812,253		1,918,913	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: 15-1303 | Component CCN: 15-Z303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/27/2018 5:06 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		183,215		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		183,215		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		41,946		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		225,161		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1303 Component CCN: 15-Z303	Period: From 07/01/2017 To 06/30/2018	Worksheet E-2 Date/Time Prepared: 11/27/2018 5:06 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)	198,051	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)	31,705	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	103	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)	229,756	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	229,756	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)	229,756	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	229,756	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	229,756	0	19.00
19.01	Sequestration adjustment (see instructions)	4,595	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	183,215	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)	41,946	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: 15-1303	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Prepared: 11/27/2018 5:06 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	940,915	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)	940,915	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	950,324	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)	950,324	19.00
20.00	Deductibles (exclude professional component)	132,944	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	817,380	22.00
23.00	Coinsurance	1,675	23.00
24.00	Subtotal (line 22 minus line 23)	815,705	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	20,192	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	13,125	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,293	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	828,830	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)	828,830	30.00
30.01	Sequestration adjustment (see instructions)	16,577	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	759,293	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)	52,960	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/27/2018 5:06 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	172,237	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	5,055,774	0	0	0	4.00
5.00	Other receivable	9,323	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,919,547	0	0	0	6.00
7.00	Inventory	210,996	0	0	0	7.00
8.00	Prepaid expenses	132,821	0	0	0	8.00
9.00	Other current assets	308,840	0	0	0	9.00
10.00	Due from other funds	-131,560	131,560	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	2,838,884	131,560	0	0	11.00
	FIXED ASSETS					
12.00	Land	127,944	0	0	0	12.00
13.00	Land improvements	420,279	0	0	0	13.00
14.00	Accumulated depreciation	-405,110	0	0	0	14.00
15.00	Buildings	14,192,681	0	0	0	15.00
16.00	Accumulated depreciation	-6,857,758	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,035,388	0	0	0	19.00
20.00	Accumulated depreciation	-962,831	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	4,500,642	0	0	0	23.00
24.00	Accumulated depreciation	-3,636,168	0	0	0	24.00
25.00	Minor equipment depreciable	201,441	0	0	0	25.00
26.00	Accumulated depreciation	-113,133	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	8,503,375	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	7,879	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,879	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	11,350,138	131,560	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	554,446	0	0	0	37.00
38.00	Salaries, wages, and fees payable	180,538	0	0	0	38.00
39.00	Payroll taxes payable	7,614	0	0	0	39.00
40.00	Notes and loans payable (short term)	141,434	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,635,098	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,519,130	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	9,924,011	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,924,011	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,443,141	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-2,093,003				52.00
53.00	Specific purpose fund		131,560			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)	-2,093,003	131,560	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,350,138	131,560	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/27/2018 5:06 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		-2,402,543		241,101		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,080,872				2.00
3.00	Total (sum of line 1 and line 2)		-1,321,671		241,101		3.00
4.00	Grant/Donation	0		34,528		0	4.00
5.00	Intercompany Transfers	-771,332		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		-771,332		34,528		10.00
11.00	Subtotal (line 3 plus line 10)		-2,093,003		275,629		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00	Grant/Donation	0		144,069		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00	Rounding	0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		144,069		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-2,093,003		131,560		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	Grant/Donation		0			4.00
5.00	Intercompany Transfers		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00	Grant/Donation		0			14.00
15.00			0			15.00
16.00			0			16.00
17.00	Rounding		0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1303 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/27/2018 5:06 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,573,481		2,573,481	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,573,481		2,573,481	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,573,481		2,573,481	17.00
18.00	Ancillary services	1,428,629	38,813,035	40,241,664	18.00
19.00	Outpatient services	224,238	19,058,289	19,282,527	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,226,348	57,871,324	62,097,672	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,760,002		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)		14,760,002		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1303	Period: From 07/01/2017 To 06/30/2018	Worksheet G-3 Date/Time Prepared: 11/27/2018 5:06 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	62,097,672	1.00
2.00	Less contractual allowances and discounts on patients' accounts	46,848,437	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,249,235	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,760,002	4.00
5.00	Net income from service to patients (line 3 minus line 4)	489,233	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2,284	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	96,694	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	3,851	17.00
18.00	Revenue from sale of medical records and abstracts	546	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	324,797	22.00
23.00	Governmental appropriations	0	23.00
24.00	Other misc revenue	19,398	24.00
24.01	Net assets released from restriction	144,069	24.01
25.00	Total other income (sum of lines 6-24)	591,639	25.00
26.00	Total (line 5 plus line 25)	1,080,872	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,080,872	29.00