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: 15-1325	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/26/2018 4:47 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/26/2018 Time: 4:47 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT WARRICK HOSPITAL (15-1325) 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	-202,396	-900,970	0	0	1.00
2.00	Subprovider - IPF	0	831	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	-642,034	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-843,599	-900,970	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: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 3:10 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1116 MILLIS AVE	PO Box:			1.00
2.00	City: BOONEVILLE	State: IN	Zip Code: 47601	County: WARRICK	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 WARRICK HOSPITAL	151325	21780	1	03/01/2005	N	O	O	3.00
4.00	Subprovider - IPF	ST. VINCENT WARRICK - PSYCH UNIT	15M325	21780	4	03/01/2005	N	P	O	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT WARRICK - SWING BED	15Z325	21780		03/01/2005	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)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 3:10 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.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 3:10 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: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 3:10 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.	Y			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)	N	N	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)	N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1325	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 3:10 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.	N	N	N	N	109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 3:10 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:	46,808	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	5.04	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	158056	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1325	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 3:10 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 SOUTHWEST INDIANA	Contractor's Name: WPS	Contractor's Number: 08101		141.00
142.00	Street: 3700 WASHINGTON AVE.	PO Box:			142.00
143.00	City: EVANSVILLE	State: IN	Zip Code: 47550		143.00

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016	09/30/2017	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 11/26/2018 3:10 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/15/2018	Y	10/15/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/26/2018 3:10 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			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: 15-1325	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/26/2018 3:10 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: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 11/26/2018 3:10 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	12,912.00	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	12,912.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	12,912.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		35				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: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2018 3:10 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)	343	47	534			1.00
2.00	HMO and other (see instructions)	92	16				2.00
3.00	HMO IPF Subprovider	84	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,115	0	1,820			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	432			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,458	47	2,786			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,458	47	2,786	0.00	63.85	14.00
15.00	CAH visits	2,930	3,820	23,975			15.00
16.00	SUBPROVIDER - IPF	3,243	0	3,521	0.00	20.51	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	84.36	27.00
28.00	Observation Bed Days		0	456			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			4			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: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2018 3:10 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	94	21	161	1.00
2.00	HMO and other (see instructions)			19	5		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	94	21	161	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	198	0	227	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/26/2018 3:10 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)	0.317040	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	-10,622	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	8,231,355	6.00
7.00	Medicaid cost (line 1 times line 6)	2,609,669	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)	2,620,291	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)	2,620,291	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,798,470	650,057	3,448,527	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	887,227	650,057	1,537,284	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,597	20,223	21,820	22.00
23.00	Cost of charity care (line 21 minus line 22)	885,630	629,834	1,515,464	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)	588,869	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	281,882	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	433,664	27.01
28.00	Non-Medicare bad debt expense (see instructions)	155,205	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	200,988	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,716,452	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,336,743	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/26/2018 3:10 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		34,207	34,207	0	34,207	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		192,385	192,385	0	192,385	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	21	1,650,189	1,650,210	0	1,650,210	4.00
5.02	00560	PURCHASING RECEIVING AND STORES	0	22,873	22,873	0	22,873	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	27,141	118,281	145,422	0	145,422	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	643,842	4,844,755	5,488,597	-195,319	5,293,278	5.04
7.00	00700	OPERATION OF PLANT	0	909,105	909,105	0	909,105	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,427	34,427	0	34,427	8.00
9.00	00900	HOUSEKEEPING	0	231,856	231,856	0	231,856	9.00
10.00	01000	DIETARY	0	420,794	420,794	-164,540	256,254	10.00
11.00	01100	CAFETERIA	0	0	0	164,540	164,540	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	195,319	195,319	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	228,659	22,576	251,235	0	251,235	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,101,353	125,139	1,226,492	0	1,226,492	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,172,866	644,354	1,817,220	0	1,817,220	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	193,874	280,618	474,492	-42,423	432,069	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	286,365	286,365	0	286,365	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,241	156,546	630,787	0	630,787	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	327,111	576,555	903,666	0	903,666	60.00
65.00	06500	RESPIRATORY THERAPY	195,519	25,696	221,215	36,366	257,581	65.00
66.00	06600	PHYSICAL THERAPY	365,875	24,339	390,214	-186,669	203,545	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	126,687	126,687	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	23,616	23,616	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,687	23,687	42,423	66,110	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,120	8,120	0	8,120	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	280,478	280,478	0	280,478	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	724,691	1,679,110	2,403,801	0	2,403,801	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,455,193	12,592,455	18,047,648	0	18,047,648	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	18,703	18,703	0	18,703	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC - MARKETING	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	5,455,193	12,611,158	18,066,351	0	18,066,351	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/26/2018 3:10 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	0	34,207		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-137,324	55,061		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-125	1,650,085		4.00
5.02	00560	PURCHASING RECEIVING AND STORES	0	22,873		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	-82,960	62,462		5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	-1,325,409	3,967,869		5.04
7.00	00700	OPERATION OF PLANT	-17,769	891,336		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,427		8.00
9.00	00900	HOUSEKEEPING	-8,040	223,816		9.00
10.00	01000	DIETARY	-48,101	208,153		10.00
11.00	01100	CAFETERIA	0	164,540		11.00
13.00	01300	NURSING ADMINISTRATION	0	195,319		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	0	251,235		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,226,492		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	-447	1,816,773		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-107,222	324,847		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-276,000	10,365		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	630,787		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-11,069	892,597		60.00
65.00	06500	RESPIRATORY THERAPY	0	257,581		65.00
66.00	06600	PHYSICAL THERAPY	-20,093	183,452		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	126,687		67.00
68.00	06800	SPEECH PATHOLOGY	0	23,616		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	66,110		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,120		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	280,478		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-432,921	1,970,880		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)	-2,467,480	15,580,168		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	18,703		194.00
194.01	07951	OTHER NRCC - JAIL	0	0		194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0		194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0		194.03
194.04	07954	OTHER NRCC - MARKETING	82,974	82,974		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,384,506	15,681,845		200.00

RECLASSIFICATIONS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 3:10 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - Nursing Admin Salaries					
1.00	NURSING ADMINISTRATION	13.00	190,901	4,418		1.00
	TOTALS		190,901	4,418		
	B - Cafeteria Expense					
1.00	CAFETERIA	11.00		164,540		1.00
			0	164,540		
	C - Supplies and Implantable Devices					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		42,423		1.00
			0	42,423		
	D - Therapy Costs					
1.00	RESPIRATORY THERAPY	65.00	35,256	1,110		1.00
2.00	OCCUPATIONAL THERAPY	67.00	112,499	14,188		2.00
3.00	SPEECH PATHOLOGY	68.00	22,704	912		3.00
			170,459	16,210		
500.00	Grand Total: Increases		361,360	227,591		500.00

RECLASSIFICATIONS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 3:10 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - Nursing Admin Salaries						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	190,901	4,418	0		1.00
	TOTALS		190,901	4,418			
	B - Cafeteria Expense						
1.00	DIETARY	10.00		164,540			1.00
			0	164,540			
	C - Supplies and Implantable Devices						
1.00	OPERATING ROOM	50.00		42,423			1.00
			0	42,423			
	D - Therapy Costs						
1.00	PHYSICAL THERAPY	66.00	170,459	16,210			1.00
2.00							2.00
3.00							3.00
			170,459	16,210			
500.00	Grand Total: Decreases		361,360	227,591			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/26/2018 3:10 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	445,242	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,751,498	508,620	0	508,620	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	8,258,335	166,491	0	166,491	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,455,075	675,111	0	675,111	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	20,455,075	675,111	0	675,111	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	445,242	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	12,260,118	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	8,424,826	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	21,130,186	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	21,130,186	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II Date/Time Prepared: 11/26/2018 3:10 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	0	625	0	33,582	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	36,881	154,673	831	0	2.00
3.00	Total (sum of lines 1-2)	0	37,506	154,673	34,413	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	34,207		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	192,385		2.00
3.00	Total (sum of lines 1-2)	0	226,592		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/26/2018 3:10 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	12,705,360	0	12,705,360	0.601290	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,424,826	0	8,424,826	0.398710	0	2.00
3.00	Total (sum of lines 1-2)	21,130,186	0	21,130,186	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	625	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	36,881	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	37,506	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	0	33,582	0	0	34,207	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,349	831	0	0	55,061	2.00
3.00	Total (sum of lines 1-2)	17,349	34,413	0	0	89,268	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/26/2018 3:10 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)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-827,132			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	-615,978			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-47,463	DIETARY	10.00	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	B	-638	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-82,954	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/26/2018 3:10 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	
33.00	OTHER ADMIN REVENUE	B	-976	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.00
33.01	OTHER MAINTENANCE REVENUE	B	-525	OPERATION OF PLANT	7.00	0	33.01
33.02	FITNESS CLUB REVENUE	B	-20,093	PHYSICAL THERAPY	66.00	0	33.02
33.03	HOUSEKEEPING REVENUE	B	-8,040	HOUSEKEEPING	9.00	0	33.03
33.04	BUILDING RENTAL INCOME	B	-17,244	OPERATION OF PLANT	7.00	0	33.04
33.05	LAB SERVICES REVENUE	B	-80	LABORATORY	60.00	0	33.05
33.06	INTEREST INCOME	B	-61,735	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.06
33.07	NON-ALLOWABLE CED SALARIES	A	-447	SUBPROVIDER - IPF	40.00	0	33.07
33.08	NON-ALLOWABLE CED BENEFITS	A	-125	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	PROVIDER TAX ADJUSTMENT	B	-613,612	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.09
33.10	PHYSICIAN BILLING COSTS	A	-6	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	33.10
33.11	CHARITABLE EXPENSE	A	-590	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.11
33.12	UNNECESSARY BORROWING	A	-75,589	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.12
33.13	COMMUNITY BENEFIT EXPENSE	A	-639	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.13
33.14	CORPORATE SPONSORSHIP	A	-10,640	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,384,506				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: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/26/2018 3:10 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	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE - CAPITAL	322,838	0	1.00
2.00	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE - OTHER	2,883,978	3,905,768	2.00
3.00	194.04	OTHER NRCC - MARKETING	HOME OFFICE - MARKETING	82,974	0	3.00
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	124,711	124,711	3.02
3.03	2.00	CAP REL COSTS-MVBLE EQUIP	INTEREST EXPENSE	126,120	126,120	3.03
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.			3,540,621	4,156,599	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	B		0.00	ASCENSION	100.00	6.00
7.00	B		0.00	ST VINCENT HLTH	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: 15-1325	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-1 Date/Time Prepared: 11/26/2018 3:10 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	322,838	0		1.00
2.00	-1,021,790	0		2.00
3.00	82,974	0		3.00
3.02	0	0		3.02
3.03	0	9		3.03
4.00	0	0		4.00
5.00	-615,978			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	CASHIERING/AR		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: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/26/2018 3:10 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	107,222	107,222	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	276,000	276,000	0	0	0	2.00
3.00	60.00	LABORATORY	10,989	10,989	0	0	0	3.00
4.00	91.00	EMERGENCY	1,300,063	432,921	867,142	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,694,274	827,132	867,142		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	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	50.00	OPERATING ROOM	0	0	0	107,222		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	276,000		2.00
3.00	60.00	LABORATORY	0	0	0	10,989		3.00
4.00	91.00	EMERGENCY	0	0	0	432,921		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	827,132		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/26/2018 3:10 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES	
			0	1.00	2.00	4.00	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	34,207	34,207				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	55,061		55,061			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,650,085	323	521	1,650,929		4.00
5.02	00560	PURCHASING RECEIVING AND STORES	22,873	608	978	0	24,459	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	62,462	1,087	1,750	8,214	0	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	3,967,869	4,531	7,291	137,076	0	5.04
7.00	00700	OPERATION OF PLANT	891,336	2,488	4,005	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,427	255	410	0	0	8.00
9.00	00900	HOUSEKEEPING	223,816	619	997	0	1,018	9.00
10.00	01000	DIETARY	208,153	1,445	2,326	0	0	10.00
11.00	01100	CAFETERIA	164,540	526	846	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	195,319	120	194	57,774	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	392	631	0	0	14.00
15.00	01500	PHARMACY	251,235	553	891	69,200	1,312	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	821	1,322	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,226,492	4,291	6,908	333,309	3,751	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,816,773	3,056	4,919	354,949	6,540	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	324,847	2,660	4,282	58,673	96	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	10,365	41	66	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	630,787	2,073	3,336	143,522	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	892,597	1,081	1,740	98,996	31	60.00
65.00	06500	RESPIRATORY THERAPY	257,581	436	702	69,841	2,207	65.00
66.00	06600	PHYSICAL THERAPY	183,452	1,211	1,949	59,140	5,278	66.00
67.00	06700	OCCUPATIONAL THERAPY	126,687	714	1,150	34,046	3,024	67.00
68.00	06800	SPEECH PATHOLOGY	23,616	19	30	6,871	339	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,110	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,120	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	280,478	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,970,880	1,605	2,584	219,318	863	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)	15,580,168	30,955	49,828	1,650,929	24,459	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	196	315	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	18,703	1,865	3,001	0	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	1,191	1,917	0	0	194.03
194.04	07954	OTHER NRCC - MARKETING	82,974	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,681,845	34,207	55,061	1,650,929	24,459	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/26/2018 3:10 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.03	5A.03	5.04	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	73,513					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	4,116,767	4,116,767			5.04
7.00	00700	OPERATION OF PLANT	0	897,829	319,596	1,217,425		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	35,092	12,492	12,312	59,896	8.00
9.00	00900	HOUSEKEEPING	0	226,450	80,608	29,947	4,253	9.00
10.00	01000	DIETARY	0	211,924	75,438	69,906	0	10.00
11.00	01100	CAFETERIA	0	165,912	59,059	25,434	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	253,407	90,204	5,827	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	1,023	364	18,950	0	14.00
15.00	01500	PHARMACY	0	323,191	115,045	26,771	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,143	763	39,718	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,414	1,580,165	562,483	207,568	17,914	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	9,087	2,195,324	781,459	147,808	12,907	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,394	393,952	140,233	128,683	3,143	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	280	10,752	3,827	1,972	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,120	795,838	283,290	100,247	6,780	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	10,452	1,004,897	357,708	52,292	629	60.00
65.00	06500	RESPIRATORY THERAPY	2,234	333,001	118,537	21,097	113	65.00
66.00	06600	PHYSICAL THERAPY	2,598	253,628	90,283	58,558	1,428	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,547	167,168	59,506	34,548	818	67.00
68.00	06800	SPEECH PATHOLOGY	277	31,152	11,089	898	93	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,079	67,189	23,917	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	735	8,855	3,152	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,784	285,262	101,543	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	15,512	2,210,762	786,957	77,639	11,818	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)	73,513	15,571,683	4,077,553	1,060,175	59,896	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	511	182	9,464	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	23,569	8,390	90,192	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	3,108	1,106	57,594	0	194.03
194.04	07954	OTHER NRCC - MARKETING	0	82,974	29,536	0	0	194.04
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)	73,513	15,681,845	4,116,767	1,217,425	59,896	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 3:10 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	341,258					9.00
10.00	01000	DIETARY	0	357,268				10.00
11.00	01100	CAFETERIA	10,436	0	260,841			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	5,533	354,971		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	20,337	14.00
15.00	01500	PHARMACY	4,744	0	6,628	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,941	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,853	223,287	66,904	95,499	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	50,757	133,981	70,244	100,266	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,890	0	10,358	14,785	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,206	0	24,052	34,333	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	27,988	0	21,770	31,075	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,453	0	11,812	16,861	0	65.00
66.00	06600	PHYSICAL THERAPY	8,349	0	8,398	11,988	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,782	0	4,716	6,732	0	67.00
68.00	06800	SPEECH PATHOLOGY	531	0	1,009	1,441	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	20,337	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	40,435	0	29,417	41,991	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	276,365	357,268	260,841	354,971	20,337	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	48,290	0	0	0	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	16,603	0	0	0	0	194.03
194.04	07954	OTHER NRCC - MARKETING	0	0	0	0	0	194.04
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)	341,258	357,268	260,841	354,971	20,337	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/26/2018 3:10 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
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 SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY	476,379					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	45,565				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	206	3,358	0	2,832,237	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	5,636	0	3,498,382	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,730	2,105	0	698,879	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	973	173	0	17,697	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,708	9,970	0	1,302,424	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	6,483	0	1,502,842	0	60.00
65.00	06500	RESPIRATORY THERAPY	93	1,385	0	516,352	0	65.00
66.00	06600	PHYSICAL THERAPY	15	1,611	0	434,258	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8	959	0	279,237	0	67.00
68.00	06800	SPEECH PATHOLOGY	2	172	0	46,387	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	669	0	112,112	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	456	0	12,463	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	457,304	2,967	0	847,076	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,340	9,621	0	3,209,980	0	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)	476,379	45,565	0	15,310,326	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	10,157	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	0	0	170,441	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	0	78,411	0	194.03
194.04	07954	OTHER NRCC - MARKETING	0	0	0	112,510	0	194.04
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	476,379	45,565	0	15,681,845	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 3:10 pm

		Cost Center Description	Total
			26.00
		GENERAL SERVICE COST CENTERS	
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.02	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	5.04
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 SERVICE & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	2,832,237
31.00	03100	INTENSIVE CARE UNIT	0
40.00	04000	SUBPROVIDER - IPF	3,498,382
41.00	04100	SUBPROVIDER - IRF	0
42.00	04200	SUBPROVIDER	0
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	698,879
51.00	05100	RECOVERY ROOM	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0
53.00	05300	ANESTHESIOLOGY	17,697
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,302,424
59.00	05900	CARDIAC CATHETERIZATION	0
60.00	06000	LABORATORY	1,502,842
65.00	06500	RESPIRATORY THERAPY	516,352
66.00	06600	PHYSICAL THERAPY	434,258
67.00	06700	OCCUPATIONAL THERAPY	279,237
68.00	06800	SPEECH PATHOLOGY	46,387
69.00	06900	ELECTROCARDIOLOGY	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	112,112
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,463
73.00	07300	DRUGS CHARGED TO PATIENTS	847,076
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0
91.00	09100	EMERGENCY	3,209,980
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	
		SPECIAL PURPOSE COST CENTERS	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,310,326
		NONREIMBURSABLE COST CENTERS	
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,157
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	170,441
194.01	07951	OTHER NRCC - JAIL	0
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0
194.03	07953	OTHER NRCC - DR. OFFICE	78,411
194.04	07954	OTHER NRCC - MARKETING	112,510
200.00		Cross Foot Adjustments	0
201.00		Negative Cost Centers	0
202.00		TOTAL (sum lines 118 through 201)	15,681,845

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 3:10 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	323	521	844	844	4.00
5.02	00560	PURCHASING RECEIVING AND STORES	0	608	978	1,586	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	104,944	1,087	1,750	107,781	4	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	326,413	4,531	7,291	338,235	70	5.04
7.00	00700	OPERATION OF PLANT	265,993	2,488	4,005	272,486	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	255	410	665	0	8.00
9.00	00900	HOUSEKEEPING	0	619	997	1,616	0	9.00
10.00	01000	DIETARY	3,557	1,445	2,326	7,328	0	10.00
11.00	01100	CAFETERIA	0	526	846	1,372	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	120	194	314	30	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	392	631	1,023	0	14.00
15.00	01500	PHARMACY	1,289	553	891	2,733	35	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	821	1,322	2,143	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,285	4,291	6,908	42,484	171	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	16,644	3,056	4,919	24,619	180	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,316	2,660	4,282	50,258	30	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	9,771	41	66	9,878	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,237	2,073	3,336	42,646	74	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	27,359	1,081	1,740	30,180	51	60.00
65.00	06500	RESPIRATORY THERAPY	9,204	436	702	10,342	36	65.00
66.00	06600	PHYSICAL THERAPY	4,569	1,211	1,949	7,729	30	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	714	1,150	1,864	17	67.00
68.00	06800	SPEECH PATHOLOGY	0	19	30	49	4	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,067	1,605	2,584	10,256	112	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)	887,648	30,955	49,828	968,431	844	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	196	315	511	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	2,237	1,865	3,001	7,103	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	1,191	1,917	3,108	0	194.03
194.04	07954	OTHER NRCC - MARKETING	0	0	0	0	0	194.04
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)	889,885	34,207	55,061	979,153	844	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/26/2018 3:10 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5.03	5.04	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00560	PURCHASING RECEIVING AND STORES	1,586					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	107,785				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	338,305			5.04
7.00	00700	OPERATION OF PLANT	0	0	26,263	298,749		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,027	3,021	4,713	8.00
9.00	00900	HOUSEKEEPING	66	0	6,624	7,349	335	9.00
10.00	01000	DIETARY	0	0	6,199	17,154	0	10.00
11.00	01100	CAFETERIA	0	0	4,853	6,241	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	7,413	1,430	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	30	4,650	0	14.00
15.00	01500	PHARMACY	85	0	9,454	6,569	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	63	9,746	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	243	7,939	46,223	50,939	1,410	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	425	13,326	64,218	36,271	1,016	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6	4,978	11,524	31,578	247	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	410	315	484	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,619	23,280	24,600	533	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2	15,328	29,395	12,832	50	60.00
65.00	06500	RESPIRATORY THERAPY	143	3,276	9,741	5,177	9	65.00
66.00	06600	PHYSICAL THERAPY	342	3,810	7,419	14,370	112	66.00
67.00	06700	OCCUPATIONAL THERAPY	196	2,268	4,890	8,478	64	67.00
68.00	06800	SPEECH PATHOLOGY	22	406	911	220	7	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,582	1,965	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,079	259	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,016	8,344	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	56	22,748	64,673	19,052	930	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)	1,586	107,785	335,083	260,161	4,713	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	15	2,322	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	0	689	22,133	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	91	14,133	0	194.03
194.04	07954	OTHER NRCC - MARKETING	0	0	2,427	0	0	194.04
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)	1,586	107,785	338,305	298,749	4,713	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/26/2018 3:10 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	15,990					9.00
10.00	01000	DIETARY	0	30,681				10.00
11.00	01100	CAFETERIA	489	0	12,955			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	275	9,462		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	5,703	14.00
15.00	01500	PHARMACY	222	0	329	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	138	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,508	19,175	3,323	2,546	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,378	11,506	3,489	2,674	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	182	0	514	394	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,556	0	1,195	915	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,311	0	1,081	828	0	60.00
65.00	06500	RESPIRATORY THERAPY	630	0	587	449	0	65.00
66.00	06600	PHYSICAL THERAPY	391	0	417	320	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	224	0	234	179	0	67.00
68.00	06800	SPEECH PATHOLOGY	25	0	50	38	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	5,703	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,895	0	1,461	1,119	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,949	30,681	12,955	9,462	5,703	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	2,263	0	0	0	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	778	0	0	0	0	194.03
194.04	07954	OTHER NRCC - MARKETING	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,990	30,681	12,955	9,462	5,703	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 3:10 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
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 SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY	19,427					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,090				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8	889	0	178,858	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	1,493	0	161,595	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	71	558	0	100,340	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	40	46	0	11,173	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	600	2,662	0	121,680	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	1,717	0	92,775	0	60.00
65.00	06500	RESPIRATORY THERAPY	4	367	0	30,761	0	65.00
66.00	06600	PHYSICAL THERAPY	1	427	0	35,368	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	254	0	18,668	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	45	0	1,777	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	177	0	9,427	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	121	0	1,459	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,648	786	0	34,794	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	55	2,548	0	124,905	0	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)	19,427	12,090	0	923,580	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	2,848	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	0	0	32,188	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	0	18,110	0	194.03
194.04	07954	OTHER NRCC - MARKETING	0	0	0	2,427	0	194.04
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,427	12,090	0	979,153	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 3:10 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.02	00560	PURCHASING RECEIVING AND STORES			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL			5.04
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 SERVICE & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	178,858		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
40.00	04000	SUBPROVIDER - IPF	161,595		40.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
42.00	04200	SUBPROVIDER	0		42.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	100,340		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	11,173		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	121,680		54.00
59.00	05900	CARDIAC CATHETERIZATION	0		59.00
60.00	06000	LABORATORY	92,775		60.00
65.00	06500	RESPIRATORY THERAPY	30,761		65.00
66.00	06600	PHYSICAL THERAPY	35,368		66.00
67.00	06700	OCCUPATIONAL THERAPY	18,668		67.00
68.00	06800	SPEECH PATHOLOGY	1,777		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,427		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,459		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,794		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	124,905		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)	923,580		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,848		190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	32,188		194.00
194.01	07951	OTHER NRCC - JAIL	0		194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0		194.02
194.03	07953	OTHER NRCC - DR. OFFICE	18,110		194.03
194.04	07954	OTHER NRCC - MARKETING	2,427		194.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	979,153		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 3:10 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			1.00	2.00	4.00	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	75,527					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		75,527				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	714	714	5,455,172			4.00
5.02	00560	PURCHASING RECEIVING AND STORES	1,342	1,342	0	13,498		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,400	2,400	27,141	0	48,291,408	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	10,006	10,006	452,941	0	0	5.04
7.00	00700	OPERATION OF PLANT	5,493	5,493	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	562	562	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,367	1,367	0	562	0	9.00
10.00	01000	DIETARY	3,191	3,191	0	0	0	10.00
11.00	01100	CAFETERIA	1,161	1,161	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	266	266	190,901	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	865	865	0	0	0	14.00
15.00	01500	PHARMACY	1,222	1,222	228,659	724	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,813	1,813	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,475	9,475	1,101,353	2,070	3,556,843	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	6,747	6,747	1,172,866	3,609	5,970,578	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,874	5,874	193,874	53	2,230,208	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	90	90	0	0	183,672	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,576	4,576	474,241	0	10,583,819	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,387	2,387	327,111	17	6,867,374	60.00
65.00	06500	RESPIRATORY THERAPY	963	963	230,775	1,218	1,467,566	65.00
66.00	06600	PHYSICAL THERAPY	2,673	2,673	195,416	2,913	1,706,809	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,577	1,577	112,499	1,669	1,016,226	67.00
68.00	06800	SPEECH PATHOLOGY	41	41	22,704	187	181,677	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	708,628	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	483,219	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,143,224	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,544	3,544	724,691	476	10,191,565	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)	68,349	68,349	5,455,172	13,498	48,291,408	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	432	432	0	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	4,117	4,117	0	0	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	2,629	2,629	0	0	0	194.03
194.04	07954	OTHER NRCC - MARKETING	0	0	0	0	0	194.04
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)	34,207	55,061	1,650,929	24,459	73,513	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.452911	0.729024	0.302636	1.812046	0.001522	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			844	1,586	107,785	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000155	0.117499	0.002232	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: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 3:10 pm

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (MINUTES OF SERVICE)	
			5A.04	5.04	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	-4,116,767	11,565,078				5.04
7.00	00700	OPERATION OF PLANT	0	897,829	55,572			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	35,092	562	18,084		8.00
9.00	00900	HOUSEKEEPING	0	226,450	1,367	1,284	17,985	9.00
10.00	01000	DIETARY	0	211,924	3,191	0	0	10.00
11.00	01100	CAFETERIA	0	165,912	1,161	0	550	11.00
13.00	01300	NURSING ADMINISTRATION	0	253,407	266	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	1,023	865	0	0	14.00
15.00	01500	PHARMACY	0	323,191	1,222	0	250	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,143	1,813	0	155	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,580,165	9,475	5,409	3,945	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	2,195,324	6,747	3,897	2,675	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	393,952	5,874	949	205	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	10,752	90	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	795,838	4,576	2,047	1,750	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	1,004,897	2,387	190	1,475	60.00
65.00	06500	RESPIRATORY THERAPY	0	333,001	963	34	709	65.00
66.00	06600	PHYSICAL THERAPY	0	253,628	2,673	431	440	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	167,168	1,577	247	252	67.00
68.00	06800	SPEECH PATHOLOGY	0	31,152	41	28	28	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	67,189	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,855	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	285,262	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,210,762	3,544	3,568	2,131	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,116,767	11,454,916	48,394	18,084	14,565	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	511	432	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	23,569	4,117	0	2,545	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	3,108	2,629	0	875	194.03
194.04	07954	OTHER NRCC - MARKETING	0	82,974	0	0	0	194.04
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)		4,116,767	1,217,425	59,896	341,258	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.355965	21.907165	3.312099	18.974590	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		338,305	298,749	4,713	15,990	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.029252	5.375891	0.260617	0.889074	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: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 3:10 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	25,071					10.00
11.00	01100	CAFETERIA	0	158,399				11.00
13.00	01300	NURSING ADMINISTRATION	0	3,360	151,014			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	100		14.00
15.00	01500	PHARMACY	0	4,025	0	0	290,858	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,669	40,628	40,628	0	126	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	9,402	42,656	42,656	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,290	6,290	0	1,056	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	594	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,606	14,606	0	8,980	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	13,220	13,220	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,173	7,173	0	57	65.00
66.00	06600	PHYSICAL THERAPY	0	5,100	5,100	0	9	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,864	2,864	0	5	67.00
68.00	06800	SPEECH PATHOLOGY	0	613	613	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	100	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	279,212	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	17,864	17,864	0	818	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)	25,071	158,399	151,014	100	290,858	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC - MARKETING	0	0	0	0	0	194.04
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)	357,268	260,841	354,971	20,337	476,379	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.250249	1.646734	2.350583	203.370000	1.637840	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	30,681	12,955	9,462	5,703	19,427	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.223765	0.081787	0.062656	57.030000	0.066792	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: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 3:10 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)		
			16.00	17.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
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 SERVICE & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	48,291,408			16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	3,556,843	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	5,970,578	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,230,208	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	183,672	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,583,819	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	6,867,374	0		60.00
65.00	06500	RESPIRATORY THERAPY	1,467,566	0		65.00
66.00	06600	PHYSICAL THERAPY	1,706,809	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,016,226	0		67.00
68.00	06800	SPEECH PATHOLOGY	181,677	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	708,628	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	483,219	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,143,224	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	10,191,565	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,291,408	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	0		194.00
194.01	07951	OTHER NRCC - JAIL	0	0		194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0		194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0		194.03
194.04	07954	OTHER NRCC - MARKETING	0	0		194.04
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)	45,565	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000944	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,090	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000250	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 3:10 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,832,237		2,832,237	0	2,832,237	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,498,382		3,498,382	0	3,498,382	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	698,879		698,879	0	698,879	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	17,697		17,697	0	17,697	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,302,424		1,302,424	0	1,302,424	54.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,502,842		1,502,842	0	1,502,842	60.00
65.00	06500	RESPIRATORY THERAPY	516,352	0	516,352	0	516,352	65.00
66.00	06600	PHYSICAL THERAPY	434,258	0	434,258	0	434,258	66.00
67.00	06700	OCCUPATIONAL THERAPY	279,237	0	279,237	0	279,237	67.00
68.00	06800	SPEECH PATHOLOGY	46,387	0	46,387	0	46,387	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	112,112		112,112	0	112,112	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,463		12,463	0	12,463	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	847,076		847,076	0	847,076	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,209,980		3,209,980	0	3,209,980	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	449,985		449,985		449,985	92.00
200.00		Subtotal (see instructions)	15,760,311	0	15,760,311	0	15,760,311	200.00
201.00		Less Observation Beds	449,985		449,985		449,985	201.00
202.00		Total (see instructions)	15,310,326	0	15,310,326	0	15,310,326	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 3:10 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,463,938		2,463,938			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
40.00	04000	SUBPROVIDER - IPF	5,970,578		5,970,578			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	362,608	1,867,600	2,230,208	0.313369	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,384	175,288	183,672	0.096351	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,892,360	8,691,459	10,583,819	0.123058	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,470,643	5,396,731	6,867,374	0.218838	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	326,708	1,140,858	1,467,566	0.351842	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	862,704	844,105	1,706,809	0.254427	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	660,848	355,378	1,016,226	0.274778	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	107,307	74,370	181,677	0.255327	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	172,035	536,593	708,628	0.158210	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	301,482	181,737	483,219	0.025792	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,851,932	1,291,292	3,143,224	0.269493	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	3,916,435	6,275,130	10,191,565	0.314964	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,038	1,088,867	1,092,905	0.411733	0.000000	92.00
200.00		Subtotal (see instructions)	20,372,000	27,919,408	48,291,408			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	20,372,000	27,919,408	48,291,408			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 3:10 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
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.313369		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.096351		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123058		54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.218838		60.00
65.00	06500	RESPIRATORY THERAPY	0.351842		65.00
66.00	06600	PHYSICAL THERAPY	0.254427		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274778		67.00
68.00	06800	SPEECH PATHOLOGY	0.255327		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.158210		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.025792		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.269493		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.314964		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.411733		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: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 3:10 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,832,237		2,832,237	0	2,832,237	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,498,382		3,498,382	0	3,498,382	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	698,879		698,879	0	698,879	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	17,697		17,697	0	17,697	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,302,424		1,302,424	0	1,302,424	54.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,502,842		1,502,842	0	1,502,842	60.00
65.00	06500	RESPIRATORY THERAPY	516,352	0	516,352	0	516,352	65.00
66.00	06600	PHYSICAL THERAPY	434,258	0	434,258	0	434,258	66.00
67.00	06700	OCCUPATIONAL THERAPY	279,237	0	279,237	0	279,237	67.00
68.00	06800	SPEECH PATHOLOGY	46,387	0	46,387	0	46,387	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	112,112		112,112	0	112,112	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,463		12,463	0	12,463	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	847,076		847,076	0	847,076	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,209,980		3,209,980	0	3,209,980	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	449,985		449,985		449,985	92.00
200.00		Subtotal (see instructions)	15,760,311	0	15,760,311	0	15,760,311	200.00
201.00		Less Observation Beds	449,985		449,985		449,985	201.00
202.00		Total (see instructions)	15,310,326	0	15,310,326	0	15,310,326	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 3:10 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,463,938		2,463,938			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
40.00	04000	SUBPROVIDER - IPF	5,970,578		5,970,578			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	362,608	1,867,600	2,230,208	0.313369	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,384	175,288	183,672	0.096351	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,892,360	8,691,459	10,583,819	0.123058	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,470,643	5,396,731	6,867,374	0.218838	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	326,708	1,140,858	1,467,566	0.351842	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	862,704	844,105	1,706,809	0.254427	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	660,848	355,378	1,016,226	0.274778	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	107,307	74,370	181,677	0.255327	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	172,035	536,593	708,628	0.158210	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	301,482	181,737	483,219	0.025792	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,851,932	1,291,292	3,143,224	0.269493	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	3,916,435	6,275,130	10,191,565	0.314964	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,038	1,088,867	1,092,905	0.411733	0.000000	92.00
200.00		Subtotal (see instructions)	20,372,000	27,919,408	48,291,408			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	20,372,000	27,919,408	48,291,408			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 3:10 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/26/2018 3:10 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	100,340	2,230,208	0.044991	16,359	736	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	11,173	183,672	0.060831	3,308	201	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	121,680	10,583,819	0.011497	98,293	1,130	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	92,775	6,867,374	0.013510	112,419	1,519	60.00
65.00	06500	RESPIRATORY THERAPY	30,761	1,467,566	0.020961	71,163	1,492	65.00
66.00	06600	PHYSICAL THERAPY	35,368	1,706,809	0.020722	18,328	380	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,668	1,016,226	0.018370	21,735	399	67.00
68.00	06800	SPEECH PATHOLOGY	1,777	181,677	0.009781	3,228	32	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,427	708,628	0.013303	51,272	682	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,459	483,219	0.003019	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,794	3,143,224	0.011070	171,273	1,896	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	124,905	10,191,565	0.012256	4,915	60	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	28,417	1,092,905	0.026001	0	0	92.00
200.00		Total (lines 50 through 199)	611,544	39,856,892		572,293	8,527	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:10 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
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: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:10 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	2,230,208	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	183,672	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,583,819	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	6,867,374	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,467,566	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,706,809	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,016,226	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	181,677	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	708,628	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	483,219	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,143,224	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	10,191,565	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,092,905	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	39,856,892		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:10 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	16,359	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	3,308	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	98,293	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	112,419	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	71,163	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	18,328	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	21,735	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,228	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	51,272	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	171,273	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	4,915	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		572,293	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 3:10 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	0.313369	0	868,529	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.096351	0	134,093	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123058	0	3,530,812	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.218838	0	1,909,850	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.351842	0	445,696	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.254427	0	297,939	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274778	0	69,050	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.255327	0	17,720	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.158210	0	258,934	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.025792	0	71,492	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.269493	0	661,521	756	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.314964	0	1,952,807	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.411733	0	353,505	0	0	92.00
200.00		Subtotal (see instructions)		0	10,571,948	756	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	10,571,948	756	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 3:10 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	272,170	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	12,920	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	434,495	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	417,948	0		60.00
65.00	06500	RESPIRATORY THERAPY	156,815	0		65.00
66.00	06600	PHYSICAL THERAPY	75,804	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	18,973	0		67.00
68.00	06800	SPEECH PATHOLOGY	4,524	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,966	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,844	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	178,275	204		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	615,064	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	145,550	0		92.00
200.00		Subtotal (see instructions)	2,375,348	204		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,375,348	204		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1325 | Component CCN: 15-M325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/26/2018 3:10 pm

Title XVIII | Subprovider - IPF | 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	100,340	2,230,208	0.044991	156	7	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	11,173	183,672	0.060831	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	121,680	10,583,819	0.011497	102,349	1,177	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	92,775	6,867,374	0.013510	473,136	6,392	60.00
65.00	06500	RESPIRATORY THERAPY	30,761	1,467,566	0.020961	38,226	801	65.00
66.00	06600	PHYSICAL THERAPY	35,368	1,706,809	0.020722	7,668	159	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,668	1,016,226	0.018370	43,927	807	67.00
68.00	06800	SPEECH PATHOLOGY	1,777	181,677	0.009781	16,271	159	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,427	708,628	0.013303	30,407	405	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,459	483,219	0.003019	54	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,794	3,143,224	0.011070	469,897	5,202	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	124,905	10,191,565	0.012256	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,092,905	0.000000	375	0	92.00
200.00		Total (lines 50 through 199)	583,127	39,856,892		1,182,466	15,109	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1325 | Component CCN: 15-M325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/26/2018 3:10 pm

Title XVIII | Subprovider - IPF | 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
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: 15-1325 | Component CCN: 15-M325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:10 pm

Title XVIII | Subprovider - IPF | 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	2,230,208	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	183,672	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,583,819	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	6,867,374	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,467,566	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,706,809	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,016,226	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	181,677	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	708,628	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	483,219	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,143,224	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	10,191,565	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,092,905	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	39,856,892		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1325 | Component CCN: 15-M325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:10 pm

Title XVIII | Subprovider - IPF | 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	156	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	102,349	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	473,136	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	38,226	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	7,668	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	43,927	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	16,271	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	30,407	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	54	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	469,897	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	375	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,182,466	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1325 | Component CCN: 15-Z325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 3:10 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	0.313369	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.096351	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123058	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.218838	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.351842	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.254427	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274778	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.255327	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	0.158210	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.025792	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.269493	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.314964	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.411733	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: 15-1325 | Component CCN: 15-Z325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 3:10 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
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
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 OTHER PASS THROUGH COSTS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 11/26/2018 3:10 pm

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
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	990	0.00	47	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	3,521	0.00	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00
200.00		Total (lines 30 through 199)		0	4,511		47	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:10 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
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: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:10 pm

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,230,208	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	183,672	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,583,819	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	6,867,374	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,467,566	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,706,809	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,016,226	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	181,677	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	708,628	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	483,219	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,143,224	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	10,191,565	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,092,905	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	39,856,892		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:10 pm

Title XIX | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	6,453	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	11,111	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,061	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,460	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,451	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	3,483	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	48	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	9,885	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	10,695	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	656	0	0	0	92.00
200.00		Total (lines 50 through 199)		51,303	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 3:10 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)	3,242	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	990	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)	534	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	910	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)	910	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	216	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)	216	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	343	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)	557	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)	558	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)	2,832,237	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)	29,661	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)	29,661	25.00
26.00	Total swing-bed cost (see instructions)	1,855,298	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	976,939	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)	976,939	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)	986.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	338,472	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)	338,472	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 3:10 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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	134,457	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	472,929	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)	549,648	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	550,634	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,100,282	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)	456	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	986.81	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	449,985	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 3:10 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	178,858	2,832,237	0.063151	449,985	28,417	90.00
91.00	Nursing School cost	0	2,832,237	0.000000	449,985	0	91.00
92.00	Allied health cost	0	2,832,237	0.000000	449,985	0	92.00
93.00	All other Medical Education	0	2,832,237	0.000000	449,985	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1325 Component CCN: 15-M325	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/26/2018 3:10 pm
	Title XVIII	Subprovider - IPF	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)	3,521	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,521	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)	3,521	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,243	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)	3,498,382	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,498,382	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,498,382	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)	993.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,222,180	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,222,180	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1325 | Component CCN: 15-M325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 3:10 pm

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	279,409	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,501,589	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)	15,109	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	15,109	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,486,480	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1325 Component CCN: 15-M325	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/26/2018 3:10 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	3,498,382	0.000000	0	0	90.00
91.00	Nursing School cost	0	3,498,382	0.000000	0	0	91.00
92.00	Allied health cost	0	3,498,382	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,498,382	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 3:10 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,242	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	990	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)	534	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	910	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)	910	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	216	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)	216	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	47	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)	2,832,237	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)	29,661	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)	29,661	25.00
26.00	Total swing-bed cost (see instructions)	1,855,298	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	976,939	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)	976,939	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)	986.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	46,380	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)	46,380	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 3:10 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	12,732	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	59,112	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	456	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	986.81	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	449,985	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 3:10 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	178,858	2,832,237	0.063151	449,985	28,417	90.00
91.00	Nursing School cost	0	2,832,237	0.000000	449,985	0	91.00
92.00	Allied health cost	0	2,832,237	0.000000	449,985	0	92.00
93.00	All other Medical Education	0	2,832,237	0.000000	449,985	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 3:10 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		311,593		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.313369	16,359	5,126	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.096351	3,308	319	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123058	98,293	12,096	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.218838	112,419	24,602	60.00
65.00	06500	RESPIRATORY THERAPY	0.351842	71,163	25,038	65.00
66.00	06600	PHYSICAL THERAPY	0.254427	18,328	4,663	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274778	21,735	5,972	67.00
68.00	06800	SPEECH PATHOLOGY	0.255327	3,228	824	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.158210	51,272	8,112	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.025792	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.269493	171,273	46,157	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.314964	4,915	1,548	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.411733	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		572,293	134,457	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)		572,293		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1325 | Component CCN: 15-M325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 3:10 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		5,306,754		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.313369	156	49	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.096351	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123058	102,349	12,595	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.218838	473,136	103,540	60.00
65.00	06500	RESPIRATORY THERAPY	0.351842	38,226	13,450	65.00
66.00	06600	PHYSICAL THERAPY	0.254427	7,668	1,951	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274778	43,927	12,070	67.00
68.00	06800	SPEECH PATHOLOGY	0.255327	16,271	4,154	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.158210	30,407	4,811	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.025792	54	1	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.269493	469,897	126,634	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.314964	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.411733	375	154	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,182,466	279,409	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,182,466		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1325 | Component CCN: 15-Z325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 3:10 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
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.313369	4,779	1,498	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.096351	827	80	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123058	53,472	6,580	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.218838	154,899	33,898	60.00
65.00	06500	RESPIRATORY THERAPY	0.351842	72,520	25,516	65.00
66.00	06600	PHYSICAL THERAPY	0.254427	405,854	103,260	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274778	289,766	79,621	67.00
68.00	06800	SPEECH PATHOLOGY	0.255327	34,191	8,730	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.158210	86,873	13,744	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.025792	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.269493	544,380	146,707	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.314964	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.411733	3,007	1,238	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,650,568	420,872	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,650,568		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 3:10 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		17,512		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.313369	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.096351	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123058	6,453	794	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.218838	11,111	2,432	60.00
65.00	06500	RESPIRATORY THERAPY	0.351842	3,061	1,077	65.00
66.00	06600	PHYSICAL THERAPY	0.254427	2,460	626	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274778	3,451	948	67.00
68.00	06800	SPEECH PATHOLOGY	0.255327	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.158210	3,483	551	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.025792	48	1	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.269493	9,885	2,664	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.314964	10,695	3,369	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.411733	656	270	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		51,303	12,732	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)		51,303		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1325 | Component CCN: 15-M325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 3:10 pm

Title XIX | Subprovider - IPF | 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
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.313369	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.096351	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123058	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.218838	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.351842	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.254427	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274778	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.255327	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.158210	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.025792	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.269493	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.314964	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.411733	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1325	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/26/2018 3:10 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,375,552	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)	2,375,552	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)	2,399,308	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)	23,229	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,742,724	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)	633,355	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)	633,355	30.00
31.00	Primary payer payments	256	31.00
32.00	Subtotal (line 30 minus line 31)	633,099	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)	424,643	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	276,018	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	373,978	36.00
37.00	Subtotal (see instructions)	909,117	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)	909,117	40.00
40.01	Sequestration adjustment (see instructions)	18,182	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,791,905	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-900,970	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: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 11/26/2018 3:10 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		501,389		1,791,905	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	01/31/2018	78,300		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		78,300		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		579,689		1,791,905	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		202,396		900,970	6.02
7.00	Total Medicare program liability (see instructions)		377,293		890,935	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: 15-1325 | Component CCN: 15-M325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/26/2018 3:10 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,682,059		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)		2,682,059		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		831		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,682,890		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1325 | Component CCN: 15-Z325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/26/2018 3:10 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		1,850,897		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	01/31/2018	264,600		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		264,600		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,115,497		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		642,034		0	6.02
7.00	Total Medicare program liability (see instructions)		1,473,463		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1325	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/26/2018 3:10 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1325 | Component CCN: 15-Z325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-2 | Date/Time Prepared: 11/26/2018 3:10 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)	1,111,285	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)	425,081	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	1,115	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,536,366	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,536,366	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,536,366	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	32,832	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)	1,503,534	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)	1,503,534	0	19.00
19.01	Sequestration adjustment (see instructions)	30,071	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	2,115,497	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)	-642,034	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: 15-1325	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Prepared: 11/26/2018 3:10 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	472,929	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)	472,929	4.00
5.00	Primary payer payments	8,036	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	469,622	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)	469,622	19.00
20.00	Deductibles (exclude professional component)	89,310	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	380,312	22.00
23.00	Coinsurance	335	23.00
24.00	Subtotal (line 22 minus line 23)	379,977	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	7,717	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	5,016	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	6,401	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	384,993	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)	384,993	30.00
30.01	Sequestration adjustment (see instructions)	7,700	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	579,689	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)	-202,396	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1325 Component CCN: 15-M325	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part II Date/Time Prepared: 11/26/2018 3:10 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,874,527	1.00
2.00	Net IPF PPS Outlier Payments	50,617	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	9.646575	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,925,144	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,925,144	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,925,144	18.00
19.00	Deductibles	153,880	19.00
20.00	Subtotal (line 18 minus line 19)	2,771,264	20.00
21.00	Coinsurance	34,469	21.00
22.00	Subtotal (line 20 minus line 21)	2,736,795	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1,304	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	848	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,304	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,737,643	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,737,643	31.00
31.01	Sequestration adjustment (see instructions)	54,753	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	2,682,059	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	831	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	50,617	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1325	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2018 3:10 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	59,112		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	59,112	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	59,112	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	17,512		8.00
9.00	Ancillary service charges	51,303	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	68,815	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	68,815	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	9,703	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	59,112	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	59,112	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	59,112	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	59,112	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	59,112	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	59,112	0	40.00
41.00	Interim payments	59,112	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/26/2018 3:10 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	320,857	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	8,252,267	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,414,388	0	0	0	6.00
7.00	Inventory	173,646	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	155,553	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,487,935	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	445,242	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	12,260,118	0	0	0	15.00
16.00	Accumulated depreciation	-9,412,404	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	8,424,826	0	0	0	19.00
20.00	Accumulated depreciation	-7,596,054	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,121,728	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	33,155	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	33,155	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	8,642,818	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	898,838	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	24,482	0	0	0	39.00
40.00	Notes and loans payable (short term)	106,072	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	8,911,002	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,940,394	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,940,394	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-1,297,576				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-1,297,576	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,642,818	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/26/2018 3:10 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		616,427		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,916,024				2.00
3.00	Total (sum of line 1 and line 2)		-1,299,597		0		3.00
4.00	Transfer to/from affiliates	2,021		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		2,021		0		10.00
11.00	Subtotal (line 3 plus line 10)		-1,297,576		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00	Rounding	0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,297,576		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Transfer to/from affiliates		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00	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: 15-1325 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/26/2018 3:10 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,569,488		2,569,488	1.00
2.00	SUBPROVIDER - IPF	5,980,155		5,980,155	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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)	8,549,643		8,549,643	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	8,549,643		8,549,643	17.00
18.00	Ancillary services	5,558,658	22,679,784	28,238,442	18.00
19.00	Outpatient services	-42,696	11,634,731	11,592,035	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)	14,065,605	34,314,515	48,380,120	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,066,351		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		18,066,351		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1325	Period: From 07/01/2017 To 06/30/2018	Worksheet G-3 Date/Time Prepared: 11/26/2018 3:10 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	48,380,120	1.00
2.00	Less contractual allowances and discounts on patients' accounts	32,432,226	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,947,894	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,066,351	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,118,457	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-17,704	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	47,463	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	638	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	Other Operating Revenue	2,202	24.00
24.01	Exercise Revenue	20,093	24.01
24.02	Housekeeping Revenue	8,040	24.02
24.05	Income - Genesis	-1,081	24.05
24.06	Building Rent	17,244	24.06
24.10	Other Revenue - Lab	80	24.10
24.11	Physician Clinic	125,458	24.11
25.00	Total other income (sum of lines 6-24)	202,433	25.00
26.00	Total (line 5 plus line 25)	-1,916,024	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)	-1,916,024	29.00