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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0153	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/19/2019 10:50 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/19/2019 Time: 10:50 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT HEART CENTER (15-0153) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 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	-55,093	-15,695	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-55,093	-15,695	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 11/19/2019 10:50 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 10580 N MERIDIAN ST	PO Box:			1.00
2.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	County: HAMILTON	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 HEART CENTER	150153	26900	1	12/05/2002	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2018	06/30/2019	20.00
21.00	Type of Control (see instructions)	4		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	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.	216	0	0	0	858	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 11/19/2019 10:50 am

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 11/19/2019 10:50 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 11/19/2019 10:50 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 11/19/2019 10:50 am

				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	Y	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?		N		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)				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.				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.					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

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		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:	0	0	456,059	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15HO46	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 11/19/2019 10:50 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 250 W. 96TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46260	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	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)	9.99	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)	10/01/2018	12/31/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part II | Date/Time Prepared: 11/19/2019 10:50 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	09/16/2019	Y	09/16/2019	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part II Date/Time Prepared: 11/19/2019 10:50 am

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ASCENSION 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: 15-0153	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/19/2019 10:50 am

		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.	MANAGER, NET REVENUE MANAGEMENT		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: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part I | Date/Time Prepared: 11/19/2019 10:50 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	107	39,055	0.00	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)		107	39,055	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		107	39,055	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		107				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: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part I | Date/Time Prepared: 11/19/2019 10:50 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,666	216	19,823			1.00
2.00	HMO and other (see instructions)	3,577	858				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	9,666	216	19,823			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)	9,666	216	19,823	0.00	347.80	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	347.80	27.00
28.00	Observation Bed Days		0	1,680			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			144			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: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part I | Date/Time Prepared: 11/19/2019 10:50 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,190	121	4,400	1.00
2.00	HMO and other (see instructions)			725	686		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	2,190	121	4,400	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part II Date/Time Prepared: 11/19/2019 10:50 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	26,483,476	0	26,483,476	723,593.27	36.60	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		3,017,037	0	3,017,037	52,483.44	57.49	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		54,715	0	54,715	797.73	68.59	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		6,271,265	0	6,271,265	131,556.35	47.67	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,554,849	0	6,554,849			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		0	0	0			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,898,427	0	1,898,427			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	51,387	0	51,387	158.56	324.09	26.00
27.00	Administrative & General	5.00	1,423,590	0	1,423,590	41,381.22	34.40	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part II | Date/Time Prepared: 11/19/2019 10:50 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		660,001	0	660,001	3,941.03	167.47	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	765,439	0	765,439	28,390.48	26.96	30.00
31.00	Laundry & Linen Service	8.00	38,401	0	38,401	2,813.52	13.65	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		707,630	0	707,630	30,405.14	23.27	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		352,243	0	352,243	13,422.14	26.24	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,706,338	0	1,706,338	39,787.70	42.89	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,621,114	0	1,621,114	34,149.51	47.47	40.00
41.00	Medical Records & Medical Records Library	16.00	198,234	0	198,234	6,122.24	32.38	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part III Date/Time Prepared: 11/19/2019 10:50 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		25,186,313	0	25,186,313	718,878.14	35.04	1.00
2.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		25,186,313	0	25,186,313	718,878.14	35.04	3.00
4.00	Subtotal other wages & related costs (see inst.)		6,325,980	0	6,325,980	132,354.08	47.80	4.00
5.00	Subtotal wage-related costs (see inst.)		8,453,276	0	8,453,276	0.00	33.56	5.00
6.00	Total (sum of lines 3 thru 5)		39,965,569	0	39,965,569	851,232.22	46.95	6.00
7.00	Total overhead cost (see instructions)		7,524,377	0	7,524,377	200,571.54	37.51	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part IV | Date/Time Prepared: 11/19/2019 10:50 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	976,326	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	194,937	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,579,544	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	755,500	9.00
10.00	Dental, Hearing and Vision Plan	100,574	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	58,027	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	3,343	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	140,179	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	56,648	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,666,784	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	10,244	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	12,744	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,554,850	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part V Date/Time Prepared: 11/19/2019 10:50 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	54,715	6,554,850	1.00
2.00	Hospital	54,715	6,554,850	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0153	Period: From 07/01/2018 To 06/30/2019	Worksheet S-10 Date/Time Prepared: 11/19/2019 10:50 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.184828	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,677,967	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	32,218,827	6.00
7.00	Medicaid cost (line 1 times line 6)	5,954,941	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,276,974	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,276,974	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)	6,288,747	2,612,129	8,900,876	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,162,337	2,612,129	3,774,466	21.00
22.00	Payments received from patients for amounts previously written off as charity care	358,433	237,986	596,419	22.00
23.00	Cost of charity care (line 21 minus line 22)	803,904	2,374,143	3,178,047	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,775,228	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	100,945	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	155,301	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,619,927	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	353,764	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,531,811	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,808,785	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A | Date/Time Prepared: 11/19/2019 10:50 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,372,796	2,372,796	-313,294	2,059,502	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,817,748	2,817,748	214,702	3,032,450	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	51,387	6,366,062	6,417,449	0	6,417,449	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,423,590	19,491,647	20,915,237	98,592	21,013,829	5.00
7.00	00700	OPERATION OF PLANT	765,439	3,507,860	4,273,299	0	4,273,299	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	38,401	239,925	278,326	0	278,326	8.00
9.00	00900	HOUSEKEEPING	0	866,309	866,309	0	866,309	9.00
10.00	01000	DIETARY	0	2,025,592	2,025,592	-1,482,778	542,814	10.00
11.00	01100	CAFETERIA	0	0	0	1,482,778	1,482,778	11.00
13.00	01300	NURSING ADMINISTRATION	1,706,338	1,678,600	3,384,938	0	3,384,938	13.00
15.00	01500	PHARMACY	1,621,114	3,537,786	5,158,900	0	5,158,900	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	198,234	188,315	386,549	0	386,549	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,211,089	1,843,498	13,054,587	0	13,054,587	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,086,869	544,646	4,631,515	0	4,631,515	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	887,424	1,020,072	1,907,496	0	1,907,496	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,011,573	858,118	2,869,691	0	2,869,691	59.00
60.00	06000	LABORATORY	0	2,472,002	2,472,002	0	2,472,002	60.00
65.00	06500	RESPIRATORY THERAPY	1,073,784	457,072	1,530,856	0	1,530,856	65.00
66.00	06600	PHYSICAL THERAPY	320,218	41,813	362,031	0	362,031	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,955,993	5,955,993	0	5,955,993	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,503,368	27,503,368	0	27,503,368	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,088,016	847,337	1,935,353	0	1,935,353	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)	26,483,476	84,636,559	111,120,035	0	111,120,035	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	307,200	307,200	0	307,200	193.01
200.00		TOTAL (SUM OF LINES 118 through 199)	26,483,476	84,943,759	111,427,235	0	111,427,235	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A | Date/Time Prepared: 11/19/2019 10:50 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	27,955	2,087,457		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	91,093	3,123,543		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,417,449		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-988,394	20,025,435		5.00
7.00	00700	OPERATION OF PLANT	0	4,273,299		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	278,326		8.00
9.00	00900	HOUSEKEEPING	-616	865,693		9.00
10.00	01000	DIETARY	0	542,814		10.00
11.00	01100	CAFETERIA	-452,694	1,030,084		11.00
13.00	01300	NURSING ADMINISTRATION	0	3,384,938		13.00
15.00	01500	PHARMACY	0	5,158,900		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,416	382,133		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-195	13,054,392		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-705,630	3,925,885		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-235,696	1,671,800		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,869,691		59.00
60.00	06000	LABORATORY	0	2,472,002		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,530,856		65.00
66.00	06600	PHYSICAL THERAPY	0	362,031		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,955,993		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,503,368		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-676,619	1,258,734		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)	-2,945,212	108,174,823		118.00
		NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MARKETING	0	307,200		193.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,945,212	108,482,023		200.00

RECLASSIFICATIONS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-6 | Date/Time Prepared: 11/19/2019 10:50 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAPITAL				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	144,352	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	98,592	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	70,350	3.00
	0		0	313,294	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	0	1,482,778	1.00
	0		0	1,482,778	
500.00	Grand Total: Increases		0	1,796,072	500.00

RECLASSIFICATIONS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-6 | Date/Time Prepared: 11/19/2019 10:50 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAPITAL						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	144,352	11		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	98,592	11		2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	70,350	11		3.00
	0		0	313,294			
	B - CAFETERIA						
1.00	DIETARY	10.00	0	1,482,778	0		1.00
	0		0	1,482,778			
500.00	Grand Total: Decreases		0	1,796,072			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-7 Part I | Date/Time Prepared: 11/19/2019 10:50 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	203,753	0	0	0	0	2.00
3.00	Buildings and Fixtures	43,744,008	0	0	0	2,564,371	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,518,937	320,564	0	320,564	0	5.00
6.00	Movable Equipment	19,799,944	1,905,160	0	1,905,160	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	67,266,642	2,225,724	0	2,225,724	2,564,371	8.00
9.00	Reconciling Items	2,901,794	-2,606,748	0	-2,606,748	0	9.00
10.00	Total (line 8 minus line 9)	64,364,848	4,832,472	0	4,832,472	2,564,371	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	203,753	0	2.00
3.00	Buildings and Fixtures	41,179,637	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	3,839,501	0	5.00
6.00	Movable Equipment	21,705,104	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	66,927,995	0	8.00
9.00	Reconciling Items	295,046	0	9.00
10.00	Total (line 8 minus line 9)	66,632,949	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-7 Part II | Date/Time Prepared: 11/19/2019 10:50 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,332,695	0	823,656	0	216,445	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,349,203	353,907	0	0	8,545	2.00
3.00	Total (sum of lines 1-2)	3,681,898	353,907	823,656	0	224,990	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	2,372,796	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	106,093	2,817,748	2.00
3.00	Total (sum of lines 1-2)	106,093	5,190,544	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-7 Part III Date/Time Prepared: 11/19/2019 10:50 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	45,222,891	0	45,222,891	0.675695	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	21,705,104	0	21,705,104	0.324305	0	2.00
3.00	Total (sum of lines 1-2)	66,927,995	0	66,927,995	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	1,360,650	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,440,296	353,907	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,800,946	353,907	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	510,362	0	216,445	0	2,087,457	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	214,702	0	8,545	106,093	3,123,543	2.00
3.00	Total (sum of lines 1-2)	725,064	0	224,990	106,093	5,211,000	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8 | Date/Time Prepared: 11/19/2019 10:50 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		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)	B	-26,645	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,636,065			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	4,334,902			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-452,694	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,416	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MARKETING	A	-675	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8 | Date/Time Prepared: 11/19/2019 10:50 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME	B	-19,500	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISC INCOME	B	-616	HOUSEKEEPING	9.00	0	33.02
33.03	REALIZED GAIN	B	94,609	CAP REL COSTS-BLDG & FIXT	1.00	9	33.03
33.04	CHARITABLE EXPENSE	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	LOBBYING DUES	A	-1,380	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	UNREALIZED GAIN ON INVESTMENTS	B	-66,654	CAP REL COSTS-BLDG & FIXT	1.00	9	33.06
33.07	PROVIDER TAX ADJUSTMENT	A	-5,261,859	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	LOSS ON SALE OF PPE	A	106,093	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	LATE PENALTY FEES	A	-988	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ENTERTAINMENT - A&G	A	-2,028	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	UNCLAIMED PROP EXEMPTIONS	B	-10,910	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	SEMINARS TUITION REV	B	689	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	INVENTORY DONATIONS MADE	A	18,120	OPERATING ROOM	50.00	0	33.13
33.14	GAIN ON SALE OF DISPOSAL	B	-15,000	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.14
33.15	ENTERTAINMENT - ROUTINE	A	-195	ADULTS & PEDIATRICS	30.00	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,945,212				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: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8-1 | Date/Time Prepared: 11/19/2019 10:50 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE - BENEFITS	4,491,483	4,491,483	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	1,890,949	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST	26,645	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	8,400,664	5,983,356	3.01
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ST. VINCENT HEALTH CHARGEBAC	1,012,465	1,012,465	4.00
4.01	7.00	OPERATION OF PLANT	ST. VINCENT HEALTH CHARGEBAC	2,500	2,500	4.01
4.02	13.00	NURSING ADMINISTRATION	ST. VINCENT HEALTH CHARGEBAC	39,172	39,172	4.02
4.03	15.00	PHARMACY	ST. VINCENT HEALTH CHARGEBAC	5,716	5,716	4.03
4.04	16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HEALTH CHARGEBAC	354,754	354,754	4.04
4.05	50.00	OPERATING ROOM	ST. VINCENT HEALTH CHARGEBAC	3,306,049	3,306,049	4.05
4.06	54.00	RADIOLOGY-DIAGNOSTIC	ST. VINCENT HEALTH CHARGEBAC	219,391	219,391	4.06
4.07	59.00	CARDIAC CATHETERIZATION	ST. VINCENT HEALTH CHARGEBAC	6,859	6,859	4.07
4.08	65.00	RESPIRATORY THERAPY	ST. VINCENT HEALTH CHARGEBAC	50,548	50,548	4.08
4.09	66.00	PHYSICAL THERAPY		10,077	10,077	4.09
4.10	91.00	EMERGENCY	ST. VINCENT HEALTH CHARGEBAC	825	825	4.10
4.11	193.01	MARKETING	ST. VINCENT HEALTH CHARGEBAC	307,200	307,200	4.11
5.00	0		0	20,125,297	15,790,395	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 HEA	74.08	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:					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: 15-0153	Period: From 07/01/2018 To 06/30/2019	Worksheet A-8-1 Date/Time Prepared: 11/19/2019 10:50 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	1,890,949	0		2.00
3.00	26,645	0		3.00
3.01	2,417,308	0		3.01
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
5.00	4,334,902			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	HEALTH SVCS		6.00
7.00	HEALTH MGMT		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: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8-2 | Date/Time Prepared: 11/19/2019 10:50 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	723,750	723,750	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	235,696	235,696	0	0	0	2.00
3.00	91.00	EMERGENCY	676,619	676,619	0	0	0	3.00
4.00	0.00		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			1,636,065	1,636,065	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		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	723,750		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	235,696		2.00
3.00	91.00	EMERGENCY	0	0	0	676,619		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,636,065		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I Date/Time Prepared: 11/19/2019 10:50 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,087,457	2,087,457				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,123,543		3,123,543			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,417,449	7,308	10,935	6,435,692		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,025,435	146,563	219,308	346,616	20,737,922	5.00
7.00	00700	OPERATION OF PLANT	4,273,299	369,505	552,905	186,369	5,382,078	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	278,326	27,784	41,575	9,350	357,035	8.00
9.00	00900	HOUSEKEEPING	865,693	59,018	88,312	0	1,013,023	9.00
10.00	01000	DIETARY	542,814	41,287	61,779	0	645,880	10.00
11.00	01100	CAFETERIA	1,030,084	48,112	71,993	0	1,150,189	11.00
13.00	01300	NURSING ADMINISTRATION	3,384,938	46,517	69,606	415,459	3,916,520	13.00
15.00	01500	PHARMACY	5,158,900	47,408	70,938	394,709	5,671,955	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	382,133	48,391	72,409	48,266	551,199	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,054,392	727,455	1,088,519	2,729,682	17,600,048	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,925,885	204,543	306,065	995,071	5,431,564	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,671,800	40,972	61,307	216,070	1,990,149	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,869,691	116,293	174,014	489,778	3,649,776	59.00
60.00	06000	LABORATORY	2,472,002	26,412	39,521	0	2,537,935	60.00
65.00	06500	RESPIRATORY THERAPY	1,530,856	67,532	101,050	261,445	1,960,883	65.00
66.00	06600	PHYSICAL THERAPY	362,031	0	0	77,967	439,998	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,955,993	0	0	0	5,955,993	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,503,368	0	0	0	27,503,368	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,258,734	62,357	93,307	264,910	1,679,308	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)	108,174,823	2,087,457	3,123,543	6,435,692	108,174,823	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	307,200	0	0	0	307,200	193.01
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)	108,482,023	2,087,457	3,123,543	6,435,692	108,482,023	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I | Date/Time Prepared: 11/19/2019 10:50 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,737,922					5.00
7.00	00700	OPERATION OF PLANT	1,272,027	6,654,105				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	84,383	118,203	559,621			8.00
9.00	00900	HOUSEKEEPING	239,423	251,083	0	1,503,529		9.00
10.00	01000	DIETARY	152,651	175,648	0	42,021	1,016,200	10.00
11.00	01100	CAFETERIA	271,841	204,686	0	48,967	0	11.00
13.00	01300	NURSING ADMINISTRATION	925,650	197,900	0	47,344	0	13.00
15.00	01500	PHARMACY	1,340,538	201,687	0	48,250	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130,273	205,869	0	49,251	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,159,683	3,094,829	349,763	740,381	1,008,223	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,283,723	870,191	53,810	208,177	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	470,362	174,306	37,667	41,700	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	862,606	494,750	37,667	118,360	0	59.00
60.00	06000	LABORATORY	599,828	112,364	0	26,881	0	60.00
65.00	06500	RESPIRATORY THERAPY	463,445	287,302	26,904	68,732	198	65.00
66.00	06600	PHYSICAL THERAPY	103,991	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,407,669	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,500,328	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	396,896	265,287	53,810	63,465	7,779	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)	20,665,317	6,654,105	559,621	1,503,529	1,016,200	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	72,605	0	0	0	0	193.01
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)	20,737,922	6,654,105	559,621	1,503,529	1,016,200	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I Date/Time Prepared: 11/19/2019 10:50 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,675,683					11.00
13.00	01300	NURSING ADMINISTRATION	102,438	5,189,852				13.00
15.00	01500	PHARMACY	87,923	290,041	7,640,394			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,762	51,995	0	1,004,349		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	899,149	2,966,132	0	190,407	31,008,615	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	204,148	673,448	0	114,065	8,839,126	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,395	215,726	0	23,423	3,018,728	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	119,464	394,091	0	306,585	5,983,299	59.00
60.00	06000	LABORATORY	0	0	0	69,864	3,346,872	60.00
65.00	06500	RESPIRATORY THERAPY	84,841	279,875	0	20,546	3,192,726	65.00
66.00	06600	PHYSICAL THERAPY	24,847	81,967	0	5,589	656,392	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	58,956	7,422,618	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	142,191	34,145,887	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,640,394	54,088	7,694,482	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	71,716	236,577	0	18,635	2,793,473	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)	1,675,683	5,189,852	7,640,394	1,004,349	108,102,218	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	379,805	193.01
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)	1,675,683	5,189,852	7,640,394	1,004,349	108,482,023	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I | Date/Time Prepared: 11/19/2019 10:50 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	31,008,615		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	8,839,126		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,018,728		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,983,299		59.00
60.00	06000	LABORATORY	0	3,346,872		60.00
65.00	06500	RESPIRATORY THERAPY	0	3,192,726		65.00
66.00	06600	PHYSICAL THERAPY	0	656,392		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,422,618		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	34,145,887		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,694,482		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	2,793,473		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	108,102,218		118.00
		NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MARKETING	0	379,805		193.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	108,482,023		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II Date/Time Prepared: 11/19/2019 10:50 am

		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	7,308	10,935	18,243	18,243	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,890,949	146,563	219,308	2,256,820	982	5.00
7.00	00700	OPERATION OF PLANT	0	369,505	552,905	922,410	528	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	27,784	41,575	69,359	26	8.00
9.00	00900	HOUSEKEEPING	0	59,018	88,312	147,330	0	9.00
10.00	01000	DIETARY	0	41,287	61,779	103,066	0	10.00
11.00	01100	CAFETERIA	0	48,112	71,993	120,105	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	46,517	69,606	116,123	1,177	13.00
15.00	01500	PHARMACY	0	47,408	70,938	118,346	1,119	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	48,391	72,409	120,800	137	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	727,455	1,088,519	1,815,974	7,741	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	204,543	306,065	510,608	2,820	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	40,972	61,307	102,279	612	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	116,293	174,014	290,307	1,388	59.00
60.00	06000	LABORATORY	0	26,412	39,521	65,933	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	67,532	101,050	168,582	741	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	221	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	62,357	93,307	155,664	751	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,890,949	2,087,457	3,123,543	7,101,949	18,243	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	0	193.01
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)	1,890,949	2,087,457	3,123,543	7,101,949	18,243	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II | Date/Time Prepared: 11/19/2019 10:50 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,257,802					5.00
7.00	00700	OPERATION OF PLANT	138,492	1,061,430				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,187	18,855	97,427			8.00
9.00	00900	HOUSEKEEPING	26,067	40,052	0	213,449		9.00
10.00	01000	DIETARY	16,620	28,018	0	5,965	153,669	10.00
11.00	01100	CAFETERIA	29,597	32,650	0	6,952	0	11.00
13.00	01300	NURSING ADMINISTRATION	100,780	31,568	0	6,721	0	13.00
15.00	01500	PHARMACY	145,951	32,172	0	6,850	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,183	32,839	0	6,992	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	452,884	493,672	60,891	105,108	152,463	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	139,765	138,809	9,368	29,554	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,211	27,805	6,558	5,920	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	93,916	78,920	6,558	16,803	0	59.00
60.00	06000	LABORATORY	65,306	17,924	0	3,816	0	60.00
65.00	06500	RESPIRATORY THERAPY	50,457	45,829	4,684	9,758	30	65.00
66.00	06600	PHYSICAL THERAPY	11,322	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	153,260	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	707,687	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	43,212	42,317	9,368	9,010	1,176	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)	2,249,897	1,061,430	97,427	213,449	153,669	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	7,905	0	0	0	0	193.01
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)	2,257,802	1,061,430	97,427	213,449	153,669	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II Date/Time Prepared: 11/19/2019 10:50 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	189,304					11.00
13.00	01300	NURSING ADMINISTRATION	11,573	267,942				13.00
15.00	01500	PHARMACY	9,933	14,974	329,345			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,781	2,684	0	179,416		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	101,576	153,136	0	34,045	3,377,490	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,063	34,769	0	20,395	909,151	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,388	11,138	0	4,188	217,099	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,496	20,346	0	54,655	576,389	59.00
60.00	06000	LABORATORY	0	0	0	12,492	165,471	60.00
65.00	06500	RESPIRATORY THERAPY	9,585	14,449	0	3,674	307,789	65.00
66.00	06600	PHYSICAL THERAPY	2,807	4,232	0	999	19,581	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,541	163,801	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25,424	733,111	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	329,345	9,671	339,016	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,102	12,214	0	3,332	285,146	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)	189,304	267,942	329,345	179,416	7,094,044	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	7,905	193.01
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)	189,304	267,942	329,345	179,416	7,101,949	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II | Date/Time Prepared: 11/19/2019 10:50 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,377,490		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	909,151		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	217,099		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	576,389		59.00
60.00	06000	LABORATORY	0	165,471		60.00
65.00	06500	RESPIRATORY THERAPY	0	307,789		65.00
66.00	06600	PHYSICAL THERAPY	0	19,581		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	163,801		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	733,111		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	339,016		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	285,146		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,094,044		118.00
		NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MARKETING	0	7,905		193.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,101,949		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B-1 | Date/Time Prepared: 11/19/2019 10:50 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	112,546					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		112,546				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	394	394	26,432,089			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,902	7,902	1,423,590	-20,737,922	87,744,101	5.00
7.00	00700	OPERATION OF PLANT	19,922	19,922	765,439	0	5,382,078	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,498	1,498	38,401	0	357,035	8.00
9.00	00900	HOUSEKEEPING	3,182	3,182	0	0	1,013,023	9.00
10.00	01000	DIETARY	2,226	2,226	0	0	645,880	10.00
11.00	01100	CAFETERIA	2,594	2,594	0	0	1,150,189	11.00
13.00	01300	NURSING ADMINISTRATION	2,508	2,508	1,706,338	0	3,916,520	13.00
15.00	01500	PHARMACY	2,556	2,556	1,621,114	0	5,671,955	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,609	2,609	198,234	0	551,199	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,221	39,221	11,211,089	0	17,600,048	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,028	11,028	4,086,869	0	5,431,564	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,209	2,209	887,424	0	1,990,149	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,270	6,270	2,011,573	0	3,649,776	59.00
60.00	06000	LABORATORY	1,424	1,424	0	0	2,537,935	60.00
65.00	06500	RESPIRATORY THERAPY	3,641	3,641	1,073,784	0	1,960,883	65.00
66.00	06600	PHYSICAL THERAPY	0	0	320,218	0	439,998	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,955,993	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	27,503,368	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,362	3,362	1,088,016	0	1,679,308	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)	112,546	112,546	26,432,089	-20,737,922	87,436,901	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	307,200	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,087,457	3,123,543	6,435,692		20,737,922	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.547589	27.753479	0.243480		0.236345	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			18,243		2,257,802	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000690		0.025732	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: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B-1 | Date/Time Prepared: 11/19/2019 10:50 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	84,328					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,498	374,410				8.00
9.00	00900	HOUSEKEEPING	3,182	0	79,648			9.00
10.00	01000	DIETARY	2,226	0	2,226	61,662		10.00
11.00	01100	CAFETERIA	2,594	0	2,594	0	650,851	11.00
13.00	01300	NURSING ADMINISTRATION	2,508	0	2,508	0	39,788	13.00
15.00	01500	PHARMACY	2,556	0	2,556	0	34,150	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,609	0	2,609	0	6,122	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,221	234,006	39,221	61,178	349,238	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,028	36,001	11,028	0	79,293	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,209	25,201	2,209	0	25,400	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,270	25,201	6,270	0	46,401	59.00
60.00	06000	LABORATORY	1,424	0	1,424	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,641	18,000	3,641	12	32,953	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	9,651	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,362	36,001	3,362	472	27,855	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)	84,328	374,410	79,648	61,662	650,851	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,654,105	559,621	1,503,529	1,016,200	1,675,683	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	78.907421	1.494674	18.877172	16.480166	2.574603	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,061,430	97,427	213,449	153,669	189,304	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	12.586922	0.260215	2.679904	2.492118	0.290856	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: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B-1 | Date/Time Prepared: 11/19/2019 10:50 am

		Cost Center Description	NURSING ADMINISTRATION (HOURS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	611,063				13.00
15.00	01500	PHARMACY	34,150	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,122	0	584,878,676		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	349,238	0	110,895,336		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	79,293	0	66,432,673		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,400	0	13,641,770		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	46,401	0	178,493,257		59.00
60.00	06000	LABORATORY	0	0	40,689,666		60.00
65.00	06500	RESPIRATORY THERAPY	32,953	0	11,966,213		65.00
66.00	06600	PHYSICAL THERAPY	9,651	0	3,255,088		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	34,336,439		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	82,813,479		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	31,501,252		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	27,855	0	10,853,503		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)	611,063	100	584,878,676		118.00
		NONREIMBURSABLE COST CENTERS					
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	MARKETING	0	0	0		193.01
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)	5,189,852	7,640,394	1,004,349		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.493154	76,403.940000	0.001717		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	267,942	329,345	179,416		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.438485	3,293.450000	0.000307		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: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

		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	31,008,615		31,008,615	0	31,008,615	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,839,126		8,839,126	0	8,839,126	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,018,728		3,018,728	0	3,018,728	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,983,299		5,983,299	0	5,983,299	59.00
60.00	06000	LABORATORY	3,346,872		3,346,872	0	3,346,872	60.00
65.00	06500	RESPIRATORY THERAPY	3,192,726	0	3,192,726	0	3,192,726	65.00
66.00	06600	PHYSICAL THERAPY	656,392	0	656,392	0	656,392	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,422,618		7,422,618	0	7,422,618	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,145,887		34,145,887	0	34,145,887	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,694,482		7,694,482	0	7,694,482	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,793,473		2,793,473	0	2,793,473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,422,661		2,422,661		2,422,661	92.00
200.00		Subtotal (see instructions)	110,524,879	0	110,524,879	0	110,524,879	200.00
201.00		Less Observation Beds	2,422,661		2,422,661		2,422,661	201.00
202.00		Total (see instructions)	108,102,218	0	108,102,218	0	108,102,218	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

		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	100,208,174		100,208,174			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	64,827,140	1,605,533	66,432,673	0.133054	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,204,966	8,436,804	13,641,770	0.221286	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	85,262,818	93,230,439	178,493,257	0.033521	0.000000	59.00
60.00	06000	LABORATORY	34,218,758	6,470,908	40,689,666	0.082254	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,979,606	3,986,607	11,966,213	0.266812	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,168,368	86,720	3,255,088	0.201651	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,808,741	4,527,698	34,336,439	0.216173	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	62,041,079	20,772,400	82,813,479	0.412323	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,700,067	3,801,185	31,501,252	0.244260	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,051,799	7,801,704	10,853,503	0.257380	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,144,135	7,543,027	10,687,162	0.226689	0.000000	92.00
200.00		Subtotal (see instructions)	426,615,651	158,263,025	584,878,676			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	426,615,651	158,263,025	584,878,676			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.133054	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.221286	54.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.033521	59.00
60.00	06000	LABORATORY	0.082254	60.00
65.00	06500	RESPIRATORY THERAPY	0.266812	65.00
66.00	06600	PHYSICAL THERAPY	0.201651	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.216173	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.412323	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244260	73.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.257380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.226689	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: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/19/2019 10:50 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,008,615		31,008,615	0	31,008,615	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,839,126		8,839,126	0	8,839,126	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,018,728		3,018,728	0	3,018,728	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,983,299		5,983,299	0	5,983,299	59.00
60.00	06000	LABORATORY	3,346,872		3,346,872	0	3,346,872	60.00
65.00	06500	RESPIRATORY THERAPY	3,192,726	0	3,192,726	0	3,192,726	65.00
66.00	06600	PHYSICAL THERAPY	656,392	0	656,392	0	656,392	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,422,618		7,422,618	0	7,422,618	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,145,887		34,145,887	0	34,145,887	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,694,482		7,694,482	0	7,694,482	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,793,473		2,793,473	0	2,793,473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,422,661		2,422,661		2,422,661	92.00
200.00		Subtotal (see instructions)	110,524,879	0	110,524,879	0	110,524,879	200.00
201.00		Less Observation Beds	2,422,661		2,422,661		2,422,661	201.00
202.00		Total (see instructions)	108,102,218	0	108,102,218	0	108,102,218	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/19/2019 10:50 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	100,208,174		100,208,174			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	64,827,140	1,605,533	66,432,673	0.133054	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,204,966	8,436,804	13,641,770	0.221286	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	85,262,818	93,230,439	178,493,257	0.033521	0.000000	59.00
60.00	06000	LABORATORY	34,218,758	6,470,908	40,689,666	0.082254	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,979,606	3,986,607	11,966,213	0.266812	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,168,368	86,720	3,255,088	0.201651	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,808,741	4,527,698	34,336,439	0.216173	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	62,041,079	20,772,400	82,813,479	0.412323	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,700,067	3,801,185	31,501,252	0.244260	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,051,799	7,801,704	10,853,503	0.257380	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,144,135	7,543,027	10,687,162	0.226689	0.000000	92.00
200.00		Subtotal (see instructions)	426,615,651	158,263,025	584,878,676			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	426,615,651	158,263,025	584,878,676			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0153	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prepared: 11/19/2019 10:50 am
	Title XIX	Hospital	Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part I | Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,377,490	0	3,377,490	21,503	157.07	30.00
200.00	Total (lines 30 through 199)	3,377,490		3,377,490	21,503		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	9,666	1,518,239	30.00
200.00	Total (lines 30 through 199)	9,666	1,518,239	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part II Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	909,151	66,432,673	0.013685	26,450,376	361,973	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	217,099	13,641,770	0.015914	4,641,193	73,860	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	576,389	178,493,257	0.003229	44,540,903	143,823	59.00
60.00	06000	LABORATORY	165,471	40,689,666	0.004067	16,985,309	69,079	60.00
65.00	06500	RESPIRATORY THERAPY	307,789	11,966,213	0.025722	3,398,262	87,410	65.00
66.00	06600	PHYSICAL THERAPY	19,581	3,255,088	0.006016	1,434,963	8,633	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	163,801	34,336,439	0.004770	12,327,446	58,802	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	733,111	82,813,479	0.008853	38,484,246	340,701	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	339,016	31,501,252	0.010762	12,610,760	135,717	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	285,146	10,853,503	0.026272	1,612,036	42,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	263,879	10,687,162	0.024691	2,389,212	58,992	92.00
200.00		Total (lines 50 through 199)	3,980,433	484,670,502		164,874,706	1,381,341	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part III Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	21,503	0.00	9,666	30.00
200.00		Total (lines 30 through 199)		0	21,503		9,666	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV | Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV | Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	66,432,673	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,641,770	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	178,493,257	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	40,689,666	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,966,213	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,255,088	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	34,336,439	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	82,813,479	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	31,501,252	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	10,853,503	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	10,687,162	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	484,670,502		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV | Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	26,450,376	0	586,805	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	4,641,193	0	3,307,373	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	44,540,903	0	39,920,944	0	59.00
60.00	06000	LABORATORY	0.000000	16,985,309	0	2,243,082	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,398,262	0	1,337,106	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,434,963	0	30,774	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	12,327,446	0	3,461,505	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	38,484,246	0	8,037,902	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	12,610,760	0	1,725,463	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	1,612,036	0	2,838,623	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,389,212	0	1,729,937	0	92.00
200.00		Total (lines 50 through 199)		164,874,706	0	65,219,514	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

		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	0.133054	586,805	0	0	78,077	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.221286	3,307,373	0	0	731,875	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.033521	39,920,944	0	0	1,338,190	59.00
60.00	06000	LABORATORY	0.082254	2,243,082	0	0	184,502	60.00
65.00	06500	RESPIRATORY THERAPY	0.266812	1,337,106	0	0	356,756	65.00
66.00	06600	PHYSICAL THERAPY	0.201651	30,774	0	0	6,206	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.216173	3,461,505	0	0	748,284	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.412323	8,037,902	0	0	3,314,212	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244260	1,725,463	0	4,731	421,462	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.257380	2,838,623	0	0	730,605	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.226689	1,729,937	0	0	392,158	92.00
200.00		Subtotal (see instructions)		65,219,514	0	4,731	8,302,327	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		65,219,514	0	4,731	8,302,327	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
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
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	1,156		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	1,156		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,156		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V Date/Time Prepared: 11/19/2019 10:50 am

Title XIX | 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	0.133054	0	72,776	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.221286	0	409,298	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.033521	0	5,122,786	0	0	59.00
60.00	06000	LABORATORY	0.082254	0	352,361	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.266812	0	242,481	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.201651	0	4,815	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.216173	0	252,252	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.412323	0	1,156,975	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244260	0	236,029	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.257380	0	374,590	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.226689	0	466,862	0	0	92.00
200.00		Subtotal (see instructions)		0	8,691,225	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	8,691,225	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V Date/Time Prepared: 11/19/2019 10:50 am

Title XIX | 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	9,683	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,572	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	171,721	0		59.00
60.00	06000	LABORATORY	28,983	0		60.00
65.00	06500	RESPIRATORY THERAPY	64,697	0		65.00
66.00	06600	PHYSICAL THERAPY	971	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,530	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	477,047	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,652	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	96,412	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	105,832	0		92.00
200.00		Subtotal (see instructions)	1,158,100	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,158,100	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	21,503	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,503	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)	19,823	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)	9,666	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	31,008,615	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)	31,008,615	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)	31,008,615	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,442.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	13,938,952	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)	13,938,952	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	31,202,203	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	45,141,155	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,518,239	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,381,341	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,899,580	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	42,241,575	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)	1,680	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,442.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,422,661	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,377,490	31,008,615	0.108921	2,422,661	263,879	90.00
91.00	Nursing School cost	0	31,008,615	0.000000	2,422,661	0	91.00
92.00	Allied health cost	0	31,008,615	0.000000	2,422,661	0	92.00
93.00	All other Medical Education	0	31,008,615	0.000000	2,422,661	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0153	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/19/2019 10:50 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	21,503	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,503	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)	19,823	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)	216	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	31,008,615	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)	31,008,615	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)	31,008,615	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,442.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	311,485	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)	311,485	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/19/2019 10:50 am

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,809,584	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,121,069	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)	1,680	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,442.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,422,661	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/19/2019 10:50 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,377,490	31,008,615	0.108921	2,422,661	263,879	90.00
91.00	Nursing School cost	0	31,008,615	0.000000	2,422,661	0	91.00
92.00	Allied health cost	0	31,008,615	0.000000	2,422,661	0	92.00
93.00	All other Medical Education	0	31,008,615	0.000000	2,422,661	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-3 | Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		42,079,962		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.133054	26,450,376	3,519,328	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.221286	4,641,193	1,027,031	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.033521	44,540,903	1,493,056	59.00
60.00	06000	LABORATORY	0.082254	16,985,309	1,397,110	60.00
65.00	06500	RESPIRATORY THERAPY	0.266812	3,398,262	906,697	65.00
66.00	06600	PHYSICAL THERAPY	0.201651	1,434,963	289,362	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.216173	12,327,446	2,664,861	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.412323	38,484,246	15,867,940	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244260	12,610,760	3,080,304	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.257380	1,612,036	414,906	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.226689	2,389,212	541,608	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		164,874,706	31,202,203	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)		164,874,706		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-3 | Date/Time Prepared: 11/19/2019 10:50 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,837,358		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.133054	2,985,725	397,263	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.221286	355,492	78,665	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.033521	5,819,603	195,079	59.00
60.00	06000	LABORATORY	0.082254	2,132,558	175,411	60.00
65.00	06500	RESPIRATORY THERAPY	0.266812	548,685	146,396	65.00
66.00	06600	PHYSICAL THERAPY	0.201651	171,253	34,533	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.216173	1,225,123	264,839	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.412323	2,550,295	1,051,545	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244260	1,795,523	438,574	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.257380	105,986	27,279	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.226689	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		17,690,243	2,809,584	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)		17,690,243		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0153	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/19/2019 10:50 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	9,160,517	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	30,883,390	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	466,862	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	102.40	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.31	30.00
31.00	Percentage of Medicaid patient days (see instructions)	5.38	31.00
32.00	Sum of lines 30 and 31	6.69	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0153	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/19/2019 10:50 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	40,510,769		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		40,510,769	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,330,312	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		43,841,081	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		43,841,081	61.00
62.00	Deductibles billed to program beneficiaries		2,235,132	62.00
63.00	Coinsurance billed to program beneficiaries		16,356	63.00
64.00	Allowable bad debts (see instructions)		42,219	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		27,442	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		5,527	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		41,617,035	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		279,157	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E Part A Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		41,896,192	71.00
71.01	Sequestration adjustment (see instructions)		837,924	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		41,113,361	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-55,093	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	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 inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/19/2019 10:50 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9,160,517	0	9,160,517		9,160,517	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	30,883,390	0		30,883,390	30,883,390	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	466,862	0	0	466,862	466,862	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	40,510,769	0	9,160,517	31,350,252	40,510,769	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	40,510,769	0	9,160,517	31,350,252	40,510,769	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	3,330,312	0	761,804	2,568,508	3,330,312	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/19/2019 10:50 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	9,922,321	33,918,760	43,841,081	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	3,258,990	0	746,215	2,512,775	3,258,990	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	27,000	0	5,440	21,560	27,000	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0136	0.0136	0.0136	0.0136		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	44,322	0	10,149	34,173	44,322	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,330,312	0	761,804	2,568,508	3,330,312	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/19/2019 10:50 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9,160,517	9,160,517		9,160,517	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	30,883,390		30,883,390	30,883,390	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	466,862	0	466,862	466,862	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	40,510,769	9,160,517	31,350,252	40,510,769	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	40,510,769	9,160,517	31,350,252	40,510,769	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	3,330,312	761,804	2,568,508	3,330,312	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			9,922,321	33,918,760	43,841,081	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	3,258,990	746,215	2,512,775	3,258,990	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	27,000	5,440	21,560	27,000	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0136	0.0136	0.0136		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	44,322	10,149	34,173	44,322	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,330,312	761,804	2,568,508	3,330,312	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	279,157	76,975	202,182	279,157	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0153	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/19/2019 10:50 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,156	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	8,302,327	2.00
3.00	OPPS payments	11,998,765	3.00
4.00	Outlier payment (see instructions)	13,529	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)	1,156	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	4,731	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)	4,731	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)	4,731	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,575	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)	1,156	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)	12,012,294	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,854,093	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)	10,159,357	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)	10,159,357	30.00
31.00	Primary payer payments	97	31.00
32.00	Subtotal (line 30 minus line 31)	10,159,260	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)	113,082	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	73,503	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	96,882	36.00
37.00	Subtotal (see instructions)	10,232,763	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)	10,232,763	40.00
40.01	Sequestration adjustment (see instructions)	204,655	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	10,043,803	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-15,695	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: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E-1 Part I Date/Time Prepared: 11/19/2019 10:50 am

Title XVIII | Hospital | 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		41,113,361		10,043,803	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)		41,113,361		10,043,803	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		55,093		15,695	6.02
7.00	Total Medicare program liability (see instructions)		41,058,268		10,028,108	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: 15-0153	Period: From 07/01/2018 To 06/30/2019	Worksheet E-1 Part II Date/Time Prepared: 11/19/2019 10:50 am
	Title XVIII	Hospital	PPS

		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	Provider CCN: 15-0153	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 11/19/2019 10:50 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	3,121,069		1.00
2.00	Medical and other services		1,158,100	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	3,121,069	1,158,100	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)	3,121,069	1,158,100	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	5,837,358		8.00
9.00	Ancillary service charges	17,690,243	8,691,225	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)	23,527,601	8,691,225	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)	23,527,601	8,691,225	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	20,406,532	7,533,125	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)	3,121,069	1,158,100	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)	3,121,069	1,158,100	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)	3,121,069	1,158,100	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)	3,121,069	1,158,100	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	3,121,069	1,158,100	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)	3,121,069	1,158,100	40.00
41.00	Interim payments	3,121,069	1,158,100	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: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G | Date/Time Prepared: 11/19/2019 10:50 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	29,261,759	0	0	0	1.00
2.00	Temporary investments	17,286,115	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	43,891,857	0	0	0	4.00
5.00	Other receivable	3,972,431	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-19,674,057	0	0	0	6.00
7.00	Inventory	2,648,783	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	77,386,888	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	203,753	0	0	0	13.00
14.00	Accumulated depreciation	-44,146	0	0	0	14.00
15.00	Buildings	41,179,637	0	0	0	15.00
16.00	Accumulated depreciation	-33,072,991	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	3,839,501	0	0	0	19.00
20.00	Accumulated depreciation	-1,796,862	0	0	0	20.00
21.00	Automobiles and trucks	26,599	0	0	0	21.00
22.00	Accumulated depreciation	-26,599	0	0	0	22.00
23.00	Major movable equipment	21,678,505	0	0	0	23.00
24.00	Accumulated depreciation	-15,114,318	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)	16,873,079	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,601,231	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,601,231	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	95,861,198	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	11,513,602	0	0	0	37.00
38.00	Salaries, wages, and fees payable	-1,568	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	10,710,205	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,222,239	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,683,461	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)	10,683,461	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,905,700	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	62,955,498				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)	62,955,498	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	95,861,198	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G-1 | Date/Time Prepared: 11/19/2019 10:50 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		53,746,012		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		59,199,626				2.00
3.00	Total (sum of line 1 and line 2)		112,945,638		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		112,945,638		0		11.00
12.00	TRANSFER FROM AFFILIATES	34,859,890		0		0	12.00
13.00	NONCONTROLLING INTEREST	15,130,250		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		49,990,140		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		62,955,498		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	TRANSFER FROM AFFILIATES		0		12.00
13.00	NONCONTROLLING INTEREST		0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0153 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/19/2019 10:50 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	100,208,175		100,208,175	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	100,208,175		100,208,175	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	100,208,175		100,208,175	17.00
18.00	Ancillary services	320,211,542	142,918,294	463,129,836	18.00
19.00	Outpatient services	6,195,934	15,344,731	21,540,665	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)	426,615,651	158,263,025	584,878,676	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		111,427,235		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)		111,427,235		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0153	Period: From 07/01/2018 To 06/30/2019	Worksheet G-3 Date/Time Prepared: 11/19/2019 10:50 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	584,878,676	1.00
2.00	Less contractual allowances and discounts on patients' accounts	415,592,154	2.00
3.00	Net patient revenues (line 1 minus line 2)	169,286,522	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	111,427,235	4.00
5.00	Net income from service to patients (line 3 minus line 4)	57,859,287	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	850,771	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	452,694	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	4,416	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	20,116	24.00
24.01	CONTRACT SERVICES REVENUE	4,649	24.01
24.02	OTHER MISC REVENUE	10,910	24.02
24.03	SEMINARS TUITION REVENUE	-689	24.03
24.04	INCOME FROM UNCONS ENTITIES	592	24.04
24.05	GAIN ON SALE OF PPE	15,000	24.05
25.00	Total other income (sum of lines 6-24)	1,358,459	25.00
26.00	Total (line 5 plus line 25)	59,217,746	26.00
27.00	DONATIONS	18,120	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	18,120	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	59,199,626	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0153	Period: From 07/01/2018 To 06/30/2019	Worksheet L Parts I-III Date/Time Prepared: 11/19/2019 10:50 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	3,258,990	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	27,000	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	54.70	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	1.31	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	5.38	8.00
9.00	Sum of lines 7 and 8	6.69	9.00
10.00	Allowable disproportionate share percentage (see instructions)	1.36	10.00
11.00	Disproportionate share adjustment (see instructions)	44,322	11.00
12.00	Total prospective capital payments (see instructions)	3,330,312	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00