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: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/25/2019 3:08 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/25/2019 Time: 3:08 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT MERCY HOSPITAL (15-1308) 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	-22,245	67,858	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	-20,270	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-42,515	67,858	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: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 3:08 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 13311 SOUTH A ST.	PO Box:			1.00
2.00	City: ELWOOD	State: IN	Zip Code: 46036-	County: MADISON	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 MERCY HOSPITAL	151308	26900	1	07/01/2001	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SWING BED - SNF	15Z308	26900		07/01/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2018	06/30/2019	20.00
21.00	Type of Control (see instructions)	1		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.	2	N		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 3:08 pm

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 11/25/2019 3:08 pm

		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: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 3:08 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 3:08 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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.		Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 3:08 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	100,335	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 3:08 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 250 WEST 96TH STREET SUITE 215	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46260	143.00

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2017	09/30/2018	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: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part II | Date/Time Prepared: 11/25/2019 3:08 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/04/2019	Y	10/04/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part II Date/Time Prepared: 11/25/2019 3:08 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	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		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: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/25/2019 3:08 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER OF REIMBURSEMENT		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: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 11/25/2019 3:08 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	17,616.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	17,616.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	DETOXIFICATION INTENSIVE CARE UNIT	35.00	0	0	0.00	0	12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	17,616.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part I | Date/Time Prepared: 11/25/2019 3:08 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	330	22	730			1.00
2.00	HMO and other (see instructions)	199	40				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	104	0	164			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)	434	22	894			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0			12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	434	22	894	0.00	70.10	14.00
15.00	CAH visits	10,063	1,127	33,430			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	70.10	27.00
28.00	Observation Bed Days		0	351			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			4			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 11/25/2019 3:08 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	96	12	218	1.00
2.00	HMO and other (see instructions)			54	14		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	DETOXIFICATION INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	96	12	218	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-10 | Date/Time Prepared: 11/25/2019 3:08 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.292829	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	649,142	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	15,344,734	6.00
7.00	Medicaid cost (line 1 times line 6)	4,493,383	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)	3,844,241	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)	3,844,241	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,454,073	1,018,650	4,472,723	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,011,453	1,018,650	2,030,103	21.00
22.00	Payments received from patients for amounts previously written off as charity care	73,577	28,535	102,112	22.00
23.00	Cost of charity care (line 21 minus line 22)	937,876	990,115	1,927,991	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)	1,085,069	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	561,706	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	864,163	27.01
28.00	Non-Medicare bad debt expense (see instructions)	220,906	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	367,145	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,295,136	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,139,377	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A | Date/Time Prepared: 11/25/2019 3:08 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		535,417	535,417	-3,924	531,493	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		632,678	632,678	0	632,678	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,906	1,392,218	1,387,312	0	1,387,312	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	414,652	6,221,332	6,635,984	3,924	6,639,908	5.00
7.00	00700	OPERATION OF PLANT	193,406	1,162,216	1,355,622	0	1,355,622	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	35,030	35,030	8.00
9.00	00900	HOUSEKEEPING	0	542,504	542,504	-35,030	507,474	9.00
10.00	01000	DIETARY	0	431,318	431,318	-344,313	87,005	10.00
11.00	01100	CAFETERIA	0	0	0	344,313	344,313	11.00
13.00	01300	NURSING ADMINISTRATION	79,921	143	80,064	0	80,064	13.00
15.00	01500	PHARMACY	271,899	3,375,262	3,647,161	-1,150	3,646,011	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13	13	0	13	16.00
17.00	01700	SOCIAL SERVICE	82,323	41,443	123,766	0	123,766	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	478,443	308,286	786,729	-705	786,024	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	358,807	329,442	688,249	-215,674	472,575	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	716,716	86,807	803,523	-1,225	802,298	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
60.00	06000	LABORATORY	0	1,084,845	1,084,845	0	1,084,845	60.00
65.00	06500	RESPIRATORY THERAPY	398,710	36,334	435,044	0	435,044	65.00
66.00	06600	PHYSICAL THERAPY	369,634	14,134	383,768	0	383,768	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,333	0	40,333	0	40,333	67.00
68.00	06800	SPEECH PATHOLOGY	50,203	50	50,253	0	50,253	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,248	10,248	241,331	251,579	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	181,815	181,815	0	181,815	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	439	439	0	439	73.00
76.00	03610	SLEEP LAB	47,641	682	48,323	0	48,323	76.00
76.01	03480	ONCOLOGY	176,526	30,534	207,060	0	207,060	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	197,539	29,519	227,058	-11,446	215,612	90.00
91.00	09100	EMERGENCY	905,547	1,632,160	2,537,707	-11,131	2,526,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,777,394	18,079,839	22,857,233	0	22,857,233	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	59	59	0	59	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	4,777,394	18,079,898	22,857,292	0	22,857,292	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A | Date/Time Prepared: 11/25/2019 3:08 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	226,044	757,537		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	632,678		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-327	1,386,985		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-763,133	5,876,775		5.00
7.00	00700	OPERATION OF PLANT	-445	1,355,177		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	35,030		8.00
9.00	00900	HOUSEKEEPING	0	507,474		9.00
10.00	01000	DIETARY	-44,544	42,461		10.00
11.00	01100	CAFETERIA	0	344,313		11.00
13.00	01300	NURSING ADMINISTRATION	-27	80,037		13.00
15.00	01500	PHARMACY	-3,633	3,642,378		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13		16.00
17.00	01700	SOCIAL SERVICE	-150	123,616		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-266,400	519,624		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0		35.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-180	472,395		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-5,202	797,096		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	-725	1,084,120		60.00
65.00	06500	RESPIRATORY THERAPY	0	435,044		65.00
66.00	06600	PHYSICAL THERAPY	0	383,768		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	40,333		67.00
68.00	06800	SPEECH PATHOLOGY	0	50,253		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	251,579		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	181,815		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	439		73.00
76.00	03610	SLEEP LAB	0	48,323		76.00
76.01	03480	ONCOLOGY	0	207,060		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	215,612		90.00
91.00	09100	EMERGENCY	-150,000	2,376,576		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)	-1,008,722	21,848,511		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	MARKETING	0	0		194.00
194.01	07951	FOUNDATION	0	59		194.01
194.02	07952	CLINIC	0	0		194.02
194.03	07953	VACANT	0	0		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,008,722	21,848,570		200.00

RECLASSIFICATIONS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-6 | Date/Time Prepared: 11/25/2019 3:08 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	0	344,313	1.00
	TOTALS		0	344,313	
	B - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	35,030	1.00
	TOTALS		0	35,030	
	C - INTEREST				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,924	1.00
	TOTALS		0	3,924	
	D - BILLABLE MED SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	241,331	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	241,331	
500.00	Grand Total: Increases		0	624,598	500.00

RECLASSIFICATIONS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-6 | Date/Time Prepared: 11/25/2019 3:08 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	0	344,313	0		1.00
	TOTALS		0	344,313			
	B - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	35,030	0		1.00
	TOTALS		0	35,030			
	C - INTEREST						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	3,924	9		1.00
	TOTALS		0	3,924			
	D - BILLABLE MED SUPPLIES						
1.00	PHARMACY	15.00	0	1,150	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	705	0		2.00
3.00	OPERATING ROOM	50.00	0	215,674	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,225	0		4.00
5.00	CLINIC	90.00	0	11,446	0		5.00
6.00	EMERGENCY	91.00	0	11,131	0		6.00
	TOTALS		0	241,331			
500.00	Grand Total: Decreases		0	624,598			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-7 Part I Date/Time Prepared: 11/25/2019 3:08 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	457,300	0	0	0	0	1.00
2.00	Land Improvements	528,489	0	0	0	0	2.00
3.00	Buildings and Fixtures	30,100,713	3,426,364	0	3,426,364	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,086,502	3,426,364	0	3,426,364	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,086,502	3,426,364	0	3,426,364	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	457,300	0	1.00
2.00	Land Improvements	528,489	0	2.00
3.00	Buildings and Fixtures	33,527,077	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,512,866	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	34,512,866	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-7 Part II | Date/Time Prepared: 11/25/2019 3:08 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	535,417	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	632,678	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,168,095	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	535,417	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	632,678	2.00
3.00	Total (sum of lines 1-2)	0	1,168,095	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-7 Part III Date/Time Prepared: 11/25/2019 3:08 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	33,527,077	0	33,527,077	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	33,527,077	0	33,527,077	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	757,537	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	632,678	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,390,215	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	757,537	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	632,678	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,390,215	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8 | Date/Time Prepared: 11/25/2019 3:08 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-182,459	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-3,924	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)	A	-7,352	ADMINISTRATIVE & GENERAL	5.00	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	-462,118			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,456,805			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-44,544	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-1,175	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8 | Date/Time Prepared: 11/25/2019 3:08 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LAB REVENUE	B	-725	LABORATORY	60.00	0	33.00
34.00	ADMIN REVENUE	B	-32,053	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	SOCIAL SERVICE REVENUE	B	-150	SOCIAL SERVICE	17.00	0	35.00
36.00	LOBBYING	A	-459	ADMINISTRATIVE & GENERAL	5.00	0	36.00
38.00	PLANT OPERATIONS REVENUE	B	-295	OPERATION OF PLANT	7.00	0	38.00
40.00	MARKETING AND COMMUNITY RELATIONS	A	-327	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	MARKETING AND COMMUNITY RELATIONS	A	-5,637	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	PROVIDER TAX	A	-1,253,465	ADMINISTRATIVE & GENERAL	5.00	0	42.00
42.05	MEDICAL AFFAIRS ADMIN	A	-23,268	ADMINISTRATIVE & GENERAL	5.00	0	42.05
42.06	GIFTS/DONATIONS EXPENSE	A	-600	ADMINISTRATIVE & GENERAL	5.00	0	42.06
43.00	ADVERTISING	A	-976	ADMINISTRATIVE & GENERAL	5.00	0	43.00
43.01	PROMOTIONAL ITEMS	A	-2,681	ADMINISTRATIVE & GENERAL	5.00	0	43.01
43.02	CORPORATE SPONSORSHIP	A	-2,805	ADMINISTRATIVE & GENERAL	5.00	0	43.02
43.03	ADVERTISING	A	-150	OPERATION OF PLANT	7.00	0	43.03
43.04	MARKETING	A	-180	OPERATING ROOM	50.00	0	43.04
43.05	PHYSICIAN FUND EXPENSE	A	-440,157	ADMINISTRATIVE & GENERAL	5.00	0	43.05
43.07	LATE PENALTY FEES	A	-27	NURSING ADMINISTRATION	13.00	0	43.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,008,722				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: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8-1 | Date/Time Prepared: 11/25/2019 3:08 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	416,020	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST	5,862	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	4,998,759	4,375,262	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION CHARGEBACK	3,587	3,587	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	ASCENSION CHARGEBACK	18,540	18,540	4.00
4.01	15.00	PHARMACY	ASCENSION CHARGEBACK	4,000	4,000	4.01
4.02	50.00	OPERATING ROOM	ASCENSION CHARGEBACK	-2,159	-2,159	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	ASCENSION CHARGEBACK	32,500	32,500	4.03
4.04	65.00	RESPIRATORY THERAPY	ASCENSION CHARGEBACK	3,744	3,744	4.04
4.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	934,227	934,227	4.05
4.06	1.00	NEW CAP REL COSTS-BLDG & FIX	INTEREST EXPENSE	408,503	0	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	2,923	0	4.07
4.08	0.00			0	0	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
4.11	0.00			0	0	4.11
4.12	0.00			0	0	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	0.00			0	0	4.18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
4.21	0.00			0	0	4.21
4.22	0.00			0	0	4.22
4.23	0.00			0	0	4.23
4.24	0.00			0	0	4.24
5.00	0		0	6,826,506	5,369,701	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	ST. VINCENT HEA	100.00	ST. VINCENT HEALTH	100.00	6.00
7.00	B	ASCENSION	100.00	ASCENSION	100.00	7.00
8.00	B	ST. VINCENT HOS	100.00	ST. VINCENT HOSPITAL	100.00	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: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet A-8-1 Date/Time Prepared: 11/25/2019 3:08 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	416,020	0		1.00
2.00	5,862	0		2.00
3.00	623,497	0		3.00
3.01	0	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	408,503	9		4.06
4.07	2,923	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.23	0	0		4.23
4.24	0	0		4.24
5.00	1,456,805			5.00

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

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

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

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

6.00	ADMINISTRATION		6.00
7.00	ADMINISTRATION		7.00
8.00	HOSPITAL		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: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8-2 | Date/Time Prepared: 11/25/2019 3:08 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	38,058	38,058	0	0	0	1.00
2.00	15.00	PHARMACY	2,458	2,458	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	266,400	266,400	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	5,202	5,202	0	0	0	4.00
5.00	91.00	EMERGENCY	1,325,165	0	1,325,165	0	0	5.00
6.00	91.00	EMERGENCY	150,000	150,000	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			1,787,283	462,118	1,325,165		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	15.00	PHARMACY	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	38,058		1.00
2.00	15.00	PHARMACY	0	0	0	2,458		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	266,400		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	5,202		4.00
5.00	91.00	EMERGENCY	0	0	0	0		5.00
6.00	91.00	EMERGENCY	0	0	0	150,000		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	462,118		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I Date/Time Prepared: 11/25/2019 3:08 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	757,537	757,537				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	632,678		632,678			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,386,985	0	12,737	1,399,722		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,876,775	280,115	13,701	121,364	6,291,955	5.00
7.00	00700	OPERATION OF PLANT	1,355,177	122,937	12,789	56,608	1,547,511	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,030	9,024	0	0	44,054	8.00
9.00	00900	HOUSEKEEPING	507,474	5,500	0	0	512,974	9.00
10.00	01000	DIETARY	42,461	14,964	0	0	57,425	10.00
11.00	01100	CAFETERIA	344,313	9,490	0	0	353,803	11.00
13.00	01300	NURSING ADMINISTRATION	80,037	10,935	0	23,392	114,364	13.00
15.00	01500	PHARMACY	3,642,378	8,415	54,183	79,582	3,784,558	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13	13,182	0	0	13,195	16.00
17.00	01700	SOCIAL SERVICE	123,616	2,598	0	24,095	150,309	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	519,624	51,564	78,175	140,035	789,398	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	472,395	50,625	164,934	105,019	792,973	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	797,096	32,500	232,376	209,774	1,271,746	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
60.00	06000	LABORATORY	1,084,120	14,232	0	0	1,098,352	60.00
65.00	06500	RESPIRATORY THERAPY	435,044	11,103	15,368	116,698	578,213	65.00
66.00	06600	PHYSICAL THERAPY	383,768	33,387	178	108,187	525,520	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,333	1,179	0	11,805	53,317	67.00
68.00	06800	SPEECH PATHOLOGY	50,253	0	0	14,694	64,947	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	251,579	0	0	0	251,579	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	181,815	0	0	0	181,815	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	439	0	0	0	439	73.00
76.00	03610	SLEEP LAB	48,323	4,729	0	13,944	66,996	76.00
76.01	03480	ONCOLOGY	207,060	2,241	0	51,667	260,968	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	215,612	9,374	0	57,817	282,803	90.00
91.00	09100	EMERGENCY	2,376,576	46,751	48,237	265,041	2,736,605	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)	21,848,511	734,845	632,678	1,399,722	21,825,819	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,196	0	0	2,196	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,276	0	0	9,276	192.00
194.00	07950	MARKETING	0	4,761	0	0	4,761	194.00
194.01	07951	FOUNDATION	59	2,015	0	0	2,074	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	0	4,444	0	0	4,444	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,848,570	757,537	632,678	1,399,722	21,848,570	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I Date/Time Prepared: 11/25/2019 3:08 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,291,955					5.00
7.00	00700	OPERATION OF PLANT	625,899	2,173,410				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,818	55,326	117,198			8.00
9.00	00900	HOUSEKEEPING	207,475	33,720	29,492	783,661		9.00
10.00	01000	DIETARY	23,226	91,747	0	0	172,398	10.00
11.00	01100	CAFETERIA	143,097	58,186	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	46,255	67,043	0	1,230	0	13.00
15.00	01500	PHARMACY	1,530,687	51,593	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,337	80,825	0	2,562	0	16.00
17.00	01700	SOCIAL SERVICE	60,793	15,927	0	410	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	319,276	316,148	36,142	298,531	172,398	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	320,722	310,391	6,558	92,198	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	514,364	199,262	11,773	68,572	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
60.00	06000	LABORATORY	444,234	87,259	0	11,685	0	60.00
65.00	06500	RESPIRATORY THERAPY	233,861	68,075	0	5,022	0	65.00
66.00	06600	PHYSICAL THERAPY	212,549	204,703	9,515	37,259	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,564	7,229	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	26,268	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	101,752	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	73,536	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	178	0	0	52,890	0	73.00
76.00	03610	SLEEP LAB	27,097	28,994	1,531	1,179	0	76.00
76.01	03480	ONCOLOGY	105,550	13,742	0	2,614	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	114,381	57,471	0	71,852	0	90.00
91.00	09100	EMERGENCY	1,106,834	286,640	22,187	136,735	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,282,753	2,034,281	117,198	782,739	172,398	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	888	13,464	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,752	56,875	0	0	0	192.00
194.00	07950	MARKETING	1,926	29,192	0	461	0	194.00
194.01	07951	FOUNDATION	839	12,352	0	461	0	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	1,797	27,246	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,291,955	2,173,410	117,198	783,661	172,398	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I Date/Time Prepared: 11/25/2019 3:08 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	555,086					11.00
13.00	01300	NURSING ADMINISTRATION	8,953	237,845				13.00
15.00	01500	PHARMACY	0	0	5,366,838			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	101,919		16.00
17.00	01700	SOCIAL SERVICE	8,953	816	0	0	237,208	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	80,577	46,938	0	3,282	230,077	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	53,718	35,796	0	13,716	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	89,530	539	0	28,872	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
60.00	06000	LABORATORY	0	0	0	15,900	0	60.00
65.00	06500	RESPIRATORY THERAPY	53,718	17,596	0	3,531	0	65.00
66.00	06600	PHYSICAL THERAPY	53,718	0	0	4,195	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,953	0	0	404	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,953	0	0	429	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,859	0	5,366,838	0	0	73.00
76.00	03610	SLEEP LAB	8,953	0	0	721	0	76.00
76.01	03480	ONCOLOGY	17,906	490	0	2,896	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	26,859	18,007	0	1,791	0	90.00
91.00	09100	EMERGENCY	107,436	117,663	0	26,182	7,131	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	555,086	237,845	5,366,838	101,919	237,208	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	555,086	237,845	5,366,838	101,919	237,208	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I Date/Time Prepared: 11/25/2019 3:08 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,292,767	0	2,292,767		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0		35.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,626,072	0	1,626,072		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,184,658	0	2,184,658		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	1,657,430	0	1,657,430		60.00
65.00	06500	RESPIRATORY THERAPY	960,016	0	960,016		65.00
66.00	06600	PHYSICAL THERAPY	1,047,459	0	1,047,459		66.00
67.00	06700	OCCUPATIONAL THERAPY	91,467	0	91,467		67.00
68.00	06800	SPEECH PATHOLOGY	100,597	0	100,597		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	353,331	0	353,331		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	255,351	0	255,351		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,447,204	0	5,447,204		73.00
76.00	03610	SLEEP LAB	135,471	0	135,471		76.00
76.01	03480	ONCOLOGY	404,166	0	404,166		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	573,164	0	573,164		90.00
91.00	09100	EMERGENCY	4,547,413	0	4,547,413		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)	21,676,566	0	21,676,566		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,548	0	16,548		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	69,903	0	69,903		192.00
194.00	07950	MARKETING	36,340	0	36,340		194.00
194.01	07951	FOUNDATION	15,726	0	15,726		194.01
194.02	07952	CLINIC	0	0	0		194.02
194.03	07953	VACANT	33,487	0	33,487		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	21,848,570	0	21,848,570		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II Date/Time Prepared: 11/25/2019 3:08 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	12,737	12,737	12,737	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	416,020	280,115	13,701	709,836	1,104	5.00
7.00	00700	OPERATION OF PLANT	0	122,937	12,789	135,726	515	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,024	0	9,024	0	8.00
9.00	00900	HOUSEKEEPING	0	5,500	0	5,500	0	9.00
10.00	01000	DIETARY	0	14,964	0	14,964	0	10.00
11.00	01100	CAFETERIA	0	9,490	0	9,490	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,935	0	10,935	213	13.00
15.00	01500	PHARMACY	0	8,415	54,183	62,598	724	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,182	0	13,182	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,598	0	2,598	219	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	51,564	78,175	129,739	1,274	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	50,625	164,934	215,559	956	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,500	232,376	264,876	1,909	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
60.00	06000	LABORATORY	0	14,232	0	14,232	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,103	15,368	26,471	1,062	65.00
66.00	06600	PHYSICAL THERAPY	0	33,387	178	33,565	984	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,179	0	1,179	107	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	134	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	4,729	0	4,729	127	76.00
76.01	03480	ONCOLOGY	0	2,241	0	2,241	470	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	9,374	0	9,374	526	90.00
91.00	09100	EMERGENCY	0	46,751	48,237	94,988	2,413	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)	416,020	734,845	632,678	1,783,543	12,737	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,196	0	2,196	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,276	0	9,276	0	192.00
194.00	07950	MARKETING	0	4,761	0	4,761	0	194.00
194.01	07951	FOUNDATION	0	2,015	0	2,015	0	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	0	4,444	0	4,444	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	416,020	757,537	632,678	1,806,235	12,737	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II Date/Time Prepared: 11/25/2019 3:08 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	710,940					5.00
7.00	00700	OPERATION OF PLANT	70,721	206,962				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,013	5,268	16,305			8.00
9.00	00900	HOUSEKEEPING	23,443	3,211	4,103	36,257		9.00
10.00	01000	DIETARY	2,624	8,737	0	0	26,325	10.00
11.00	01100	CAFETERIA	16,169	5,541	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,226	6,384	0	57	0	13.00
15.00	01500	PHARMACY	172,958	4,913	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	603	7,696	0	119	0	16.00
17.00	01700	SOCIAL SERVICE	6,869	1,517	0	19	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,075	30,105	5,028	13,811	26,325	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,239	29,557	912	4,266	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,119	18,975	1,638	3,173	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
60.00	06000	LABORATORY	50,195	8,309	0	541	0	60.00
65.00	06500	RESPIRATORY THERAPY	26,424	6,482	0	232	0	65.00
66.00	06600	PHYSICAL THERAPY	24,016	19,493	1,324	1,724	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,437	688	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,968	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,497	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	8,309	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20	0	0	2,447	0	73.00
76.00	03610	SLEEP LAB	3,062	2,761	213	55	0	76.00
76.01	03480	ONCOLOGY	11,926	1,309	0	121	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,924	5,473	0	3,324	0	90.00
91.00	09100	EMERGENCY	125,063	27,295	3,087	6,326	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	709,900	193,714	16,305	36,215	26,325	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	100	1,282	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	424	5,416	0	0	0	192.00
194.00	07950	MARKETING	218	2,780	0	21	0	194.00
194.01	07951	FOUNDATION	95	1,176	0	21	0	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	203	2,594	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	710,940	206,962	16,305	36,257	26,325	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II Date/Time Prepared: 11/25/2019 3:08 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	31,200					11.00
13.00	01300	NURSING ADMINISTRATION	503	23,318				13.00
15.00	01500	PHARMACY	0	0	241,193			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	21,600		16.00
17.00	01700	SOCIAL SERVICE	503	80	0	0	11,805	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,529	4,602	0	695	11,450	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,019	3,509	0	2,905	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,032	53	0	6,127	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
60.00	06000	LABORATORY	0	0	0	3,368	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,019	1,725	0	748	0	65.00
66.00	06600	PHYSICAL THERAPY	3,019	0	0	889	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	503	0	0	86	0	67.00
68.00	06800	SPEECH PATHOLOGY	503	0	0	91	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,510	0	241,193	0	0	73.00
76.00	03610	SLEEP LAB	503	0	0	153	0	76.00
76.01	03480	ONCOLOGY	1,006	48	0	613	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,510	1,765	0	379	0	90.00
91.00	09100	EMERGENCY	6,041	11,536	0	5,546	355	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)	31,200	23,318	241,193	21,600	11,805	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,200	23,318	241,193	21,600	11,805	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II Date/Time Prepared: 11/25/2019 3:08 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	263,633	0	263,633		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0		35.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	296,922	0	296,922		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	359,902	0	359,902		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	76,645	0	76,645		60.00
65.00	06500	RESPIRATORY THERAPY	66,163	0	66,163		65.00
66.00	06600	PHYSICAL THERAPY	85,014	0	85,014		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,000	0	5,000		67.00
68.00	06800	SPEECH PATHOLOGY	3,696	0	3,696		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,497	0	11,497		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	8,309	0	8,309		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	245,170	0	245,170		73.00
76.00	03610	SLEEP LAB	11,603	0	11,603		76.00
76.01	03480	ONCOLOGY	17,734	0	17,734		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	35,275	0	35,275		90.00
91.00	09100	EMERGENCY	282,650	0	282,650		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)	1,769,213	0	1,769,213		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,578	0	3,578		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,116	0	15,116		192.00
194.00	07950	MARKETING	7,780	0	7,780		194.00
194.01	07951	FOUNDATION	3,307	0	3,307		194.01
194.02	07952	CLINIC	0	0	0		194.02
194.03	07953	VACANT	7,241	0	7,241		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,806,235	0	1,806,235		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B-1 | Date/Time Prepared: 11/25/2019 3:08 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DIRECT COST)	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	NEW CAP REL COSTS-BLDG & FIXT	116,942					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		632,937				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,742	4,782,300			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	43,242	13,707	414,652	-6,291,955	15,556,615	5.00
7.00	00700	OPERATION OF PLANT	18,978	12,794	193,406	0	1,547,511	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,393	0	0	0	44,054	8.00
9.00	00900	HOUSEKEEPING	849	0	0	0	512,974	9.00
10.00	01000	DIETARY	2,310	0	0	0	57,425	10.00
11.00	01100	CAFETERIA	1,465	0	0	0	353,803	11.00
13.00	01300	NURSING ADMINISTRATION	1,688	0	79,921	0	114,364	13.00
15.00	01500	PHARMACY	1,299	54,205	271,899	0	3,784,558	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,035	0	0	0	13,195	16.00
17.00	01700	SOCIAL SERVICE	401	0	82,323	0	150,309	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,960	78,207	478,443	0	789,398	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,815	165,001	358,807	0	792,973	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,017	232,472	716,716	0	1,271,746	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
60.00	06000	LABORATORY	2,197	0	0	0	1,098,352	60.00
65.00	06500	RESPIRATORY THERAPY	1,714	15,374	398,710	0	578,213	65.00
66.00	06600	PHYSICAL THERAPY	5,154	178	369,634	0	525,520	66.00
67.00	06700	OCCUPATIONAL THERAPY	182	0	40,333	0	53,317	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	50,203	0	64,947	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	251,579	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	181,815	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	439	73.00
76.00	03610	SLEEP LAB	730	0	47,641	0	66,996	76.00
76.01	03480	ONCOLOGY	346	0	176,526	0	260,968	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,447	0	197,539	0	282,803	90.00
91.00	09100	EMERGENCY	7,217	48,257	905,547	0	2,736,605	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)	113,439	632,937	4,782,300	-6,291,955	15,533,864	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	339	0	0	0	2,196	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,432	0	0	0	9,276	192.00
194.00	07950	MARKETING	735	0	0	0	4,761	194.00
194.01	07951	FOUNDATION	311	0	0	0	2,074	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	686	0	0	0	4,444	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	757,537	632,678	1,399,722		6,291,955	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.477886	0.999591	0.292688		0.404455	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,737		710,940	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002663		0.045700	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: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B-1 | Date/Time Prepared: 11/25/2019 3:08 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	54,722					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,393	112,145				8.00
9.00	00900	HOUSEKEEPING	849	28,220	15,291			9.00
10.00	01000	DIETARY	2,310	0	0	734		10.00
11.00	01100	CAFETERIA	1,465	0	0	0	62	11.00
13.00	01300	NURSING ADMINISTRATION	1,688	0	24	0	1	13.00
15.00	01500	PHARMACY	1,299	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,035	0	50	0	0	16.00
17.00	01700	SOCIAL SERVICE	401	0	8	0	1	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,960	34,585	5,825	734	9	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,815	6,275	1,799	0	6	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,017	11,265	1,338	0	10	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
60.00	06000	LABORATORY	2,197	0	228	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,714	0	98	0	6	65.00
66.00	06600	PHYSICAL THERAPY	5,154	9,105	727	0	6	66.00
67.00	06700	OCCUPATIONAL THERAPY	182	0	0	0	1	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,032	0	3	73.00
76.00	03610	SLEEP LAB	730	1,465	23	0	1	76.00
76.01	03480	ONCOLOGY	346	0	51	0	2	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,447	0	1,402	0	3	90.00
91.00	09100	EMERGENCY	7,217	21,230	2,668	0	12	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)	51,219	112,145	15,273	734	62	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	339	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,432	0	0	0	0	192.00
194.00	07950	MARKETING	735	0	9	0	0	194.00
194.01	07951	FOUNDATION	311	0	9	0	0	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	686	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,173,410	117,198	783,661	172,398	555,086	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.717298	1.045058	51.249820	234.874659	8,953.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	206,962	16,305	36,257	26,325	31,200	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.782062	0.145392	2.371133	35.865123	503.225806	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: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B-1 | Date/Time Prepared: 11/25/2019 3:08 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)		
			13.00	15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	48,093					13.00
15.00	01500	PHARMACY	0	1,000				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	58,498,770			16.00
17.00	01700	SOCIAL SERVICE	165	0	0	4,990		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,491	0	1,883,902	4,840		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0		35.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,238	0	7,873,964	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109	0	16,565,366	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
60.00	06000	LABORATORY	0	0	9,127,416	0		60.00
65.00	06500	RESPIRATORY THERAPY	3,558	0	2,027,019	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,408,136	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	232,148	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	246,457	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,000	0	0		73.00
76.00	03610	SLEEP LAB	0	0	413,993	0		76.00
76.01	03480	ONCOLOGY	99	0	1,662,231	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,641	0	1,028,027	0		90.00
91.00	09100	EMERGENCY	23,792	0	15,030,111	150		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,093	1,000	58,498,770	4,990		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	MARKETING	0	0	0	0		194.00
194.01	07951	FOUNDATION	0	0	0	0		194.01
194.02	07952	CLINIC	0	0	0	0		194.02
194.03	07953	VACANT	0	0	0	0		194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	237,845	5,366,838	101,919	237,208		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.945522	5,366.838000	0.001742	47.536673		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	23,318	241,193	21,600	11,805		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.484852	241.193000	0.000369	2.365731		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: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,292,767		2,292,767	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0		0	0	0	35.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,626,072		1,626,072	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,184,658		2,184,658	0	0	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,657,430		1,657,430	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	960,016	0	960,016	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,047,459	0	1,047,459	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,467	0	91,467	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	100,597	0	100,597	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	353,331		353,331	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	255,351		255,351	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,447,204		5,447,204	0	0	73.00
76.00	03610	SLEEP LAB	135,471		135,471	0	0	76.00
76.01	03480	ONCOLOGY	404,166		404,166	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	573,164		573,164	0	0	90.00
91.00	09100	EMERGENCY	4,547,413		4,547,413	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	646,395		646,395		0	92.00
200.00		Subtotal (see instructions)	22,322,961	0	22,322,961	0	0	200.00
201.00		Less Observation Beds	646,395		646,395		0	201.00
202.00		Total (see instructions)	21,676,566	0	21,676,566	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,369,093		1,369,093			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0		0			35.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	968,525	6,905,439	7,873,964	0.206513	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	461,869	16,103,497	16,565,366	0.131881	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
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
60.00	06000	LABORATORY	588,201	8,539,215	9,127,416	0.181588	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	393,101	1,633,918	2,027,019	0.473610	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	179,458	2,190,558	2,370,016	0.441963	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,003	214,355	235,358	0.388629	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,025	267,341	281,366	0.357531	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	372,959	1,170,339	1,543,298	0.228945	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	9,759	60,260	70,019	3.646882	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	780,143	13,132,466	13,912,609	0.391530	0.000000	73.00
76.00	03610	SLEEP LAB	0	413,993	413,993	0.327230	0.000000	76.00
76.01	03480	ONCOLOGY	2,597	1,659,634	1,662,231	0.243147	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,061	1,018,966	1,028,027	0.557538	0.000000	90.00
91.00	09100	EMERGENCY	170,952	14,859,159	15,030,111	0.302554	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	21,633	493,176	514,809	1.255602	0.000000	92.00
200.00		Subtotal (see instructions)	5,362,379	68,662,316	74,024,695			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,362,379	68,662,316	74,024,695			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		35.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03610	SLEEP LAB	0.000000	76.00
76.01	03480	ONCOLOGY	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/25/2019 3:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,292,767		2,292,767	0	2,292,767	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0		0	0	0	35.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,626,072		1,626,072	0	1,626,072	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,184,658		2,184,658	0	2,184,658	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,657,430		1,657,430	0	1,657,430	60.00
65.00	06500	RESPIRATORY THERAPY	960,016	0	960,016	0	960,016	65.00
66.00	06600	PHYSICAL THERAPY	1,047,459	0	1,047,459	0	1,047,459	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,467	0	91,467	0	91,467	67.00
68.00	06800	SPEECH PATHOLOGY	100,597	0	100,597	0	100,597	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	353,331		353,331	0	353,331	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	255,351		255,351	0	255,351	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,447,204		5,447,204	0	5,447,204	73.00
76.00	03610	SLEEP LAB	135,471		135,471	0	135,471	76.00
76.01	03480	ONCOLOGY	404,166		404,166	0	404,166	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	573,164		573,164	0	573,164	90.00
91.00	09100	EMERGENCY	4,547,413		4,547,413	0	4,547,413	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	646,395		646,395		646,395	92.00
200.00		Subtotal (see instructions)	22,322,961	0	22,322,961	0	22,322,961	200.00
201.00		Less Observation Beds	646,395		646,395		646,395	201.00
202.00		Total (see instructions)	21,676,566	0	21,676,566	0	21,676,566	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/25/2019 3:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,369,093		1,369,093			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0		0			35.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	968,525	6,905,439	7,873,964	0.206513	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	461,869	16,103,497	16,565,366	0.131881	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
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
60.00	06000	LABORATORY	588,201	8,539,215	9,127,416	0.181588	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	393,101	1,633,918	2,027,019	0.473610	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	179,458	2,190,558	2,370,016	0.441963	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,003	214,355	235,358	0.388629	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,025	267,341	281,366	0.357531	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	372,959	1,170,339	1,543,298	0.228945	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	9,759	60,260	70,019	3.646882	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	780,143	13,132,466	13,912,609	0.391530	0.000000	73.00
76.00	03610	SLEEP LAB	0	413,993	413,993	0.327230	0.000000	76.00
76.01	03480	ONCOLOGY	2,597	1,659,634	1,662,231	0.243147	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,061	1,018,966	1,028,027	0.557538	0.000000	90.00
91.00	09100	EMERGENCY	170,952	14,859,159	15,030,111	0.302554	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	21,633	493,176	514,809	1.255602	0.000000	92.00
200.00		Subtotal (see instructions)	5,362,379	68,662,316	74,024,695			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,362,379	68,662,316	74,024,695			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/25/2019 3:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT			35.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03610	SLEEP LAB	0.000000		76.00
76.01	03480	ONCOLOGY	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part II Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	296,922	7,873,964	0.037709	261,980	9,879	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	359,902	16,565,366	0.021726	100,013	2,173	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
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
60.00	06000	LABORATORY	76,645	9,127,416	0.008397	215,277	1,808	60.00
65.00	06500	RESPIRATORY THERAPY	66,163	2,027,019	0.032641	218,527	7,133	65.00
66.00	06600	PHYSICAL THERAPY	85,014	2,370,016	0.035871	45,397	1,628	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,000	235,358	0.021244	12,721	270	67.00
68.00	06800	SPEECH PATHOLOGY	3,696	281,366	0.013136	9,036	119	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,497	1,543,298	0.007450	138,137	1,029	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	8,309	70,019	0.118668	1,352	160	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	245,170	13,912,609	0.017622	246,551	4,345	73.00
76.00	03610	SLEEP LAB	11,603	413,993	0.028027	0	0	76.00
76.01	03480	ONCOLOGY	17,734	1,662,231	0.010669	203	2	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	35,275	1,028,027	0.034313	3,280	113	90.00
91.00	09100	EMERGENCY	282,650	15,030,111	0.018806	136	3	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	74,326	514,809	0.144376	0	0	92.00
200.00		Total (lines 50 through 199)	1,579,906	72,655,602		1,252,610	28,662	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Hospital | Cost

		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	7,873,964	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,565,366	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
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
60.00	06000	LABORATORY	0	0	0	9,127,416	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,027,019	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,370,016	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	235,358	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	281,366	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,543,298	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	70,019	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,912,609	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	413,993	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	1,662,231	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,028,027	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	15,030,111	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	514,809	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	72,655,602		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	261,980	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	100,013	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
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
60.00	06000	LABORATORY	0.000000	215,277	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	218,527	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	45,397	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	12,721	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	9,036	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	138,137	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	1,352	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	246,551	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	203	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	3,280	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	136	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,252,610	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.206513	0	1,829,597	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131881	0	4,144,307	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
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
60.00	06000	LABORATORY	0.181588	0	2,514,912	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.473610	0	897,568	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.441963	0	556,009	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388629	0	53,634	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.357531	0	48,721	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.228945	0	308,652	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3.646882	0	15,808	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.391530	0	5,724,484	1,309	0	73.00
76.00	03610	SLEEP LAB	0.327230	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.243147	0	173,266	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.557538	0	341,744	0	0	90.00
91.00	09100	EMERGENCY	0.302554	0	2,998,292	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.255602	0	196,336	0	0	92.00
200.00		Subtotal (see instructions)		0	19,803,330	1,309	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	19,803,330	1,309	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	377,836	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	546,555	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	456,678	0		60.00
65.00	06500	RESPIRATORY THERAPY	425,097	0		65.00
66.00	06600	PHYSICAL THERAPY	245,735	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	20,844	0		67.00
68.00	06800	SPEECH PATHOLOGY	17,419	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	70,664	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	57,650	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,241,307	513		73.00
76.00	03610	SLEEP LAB	0	0		76.00
76.01	03480	ONCOLOGY	42,129	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	190,535	0		90.00
91.00	09100	EMERGENCY	907,145	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	246,520	0		92.00
200.00		Subtotal (see instructions)	5,846,114	513		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,846,114	513		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1308 | Component CCN: 15-Z308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.206513	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131881	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
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
60.00	06000	LABORATORY	0.181588	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.473610	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.441963	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388629	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.357531	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.228945	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3.646882	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.391530	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0.327230	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.243147	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.557538	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.302554	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.255602	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1308 | Component CCN: 15-Z308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03610	SLEEP LAB	0	0	76.00
76.01	03480	ONCOLOGY	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part III Date/Time Prepared: 11/25/2019 3:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,081	0.00	22	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0	0	0.00	0	35.00
200.00		Total (lines 30 through 199)		0	1,081		22	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0		35.00
200.00		Total (lines 30 through 199)	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV Date/Time Prepared: 11/25/2019 3:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV Date/Time Prepared: 11/25/2019 3:08 pm

Title XIX | Hospital | Cost

		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	7,873,964	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,565,366	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
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
60.00	06000	LABORATORY	0	0	0	9,127,416	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,027,019	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,370,016	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	235,358	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	281,366	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,543,298	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	70,019	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,912,609	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	413,993	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	1,662,231	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,028,027	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	15,030,111	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	514,809	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	72,655,602		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV Date/Time Prepared: 11/25/2019 3:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	21,782	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	26,094	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
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
60.00	06000	LABORATORY	0.000000	36,469	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	16,788	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	8,157	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	20,031	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	28,425	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		157,746	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,245	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,081	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)	730	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	92	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)	72	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)	330	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)	92	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)	12	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,292,767	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)	302,019	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,990,748	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)	1,990,748	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)	1,841.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	607,721	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)	607,721	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	373,128	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	980,849	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)	169,425	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	22,099	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	191,524	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)	351	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,841.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	646,395	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	263,633	2,292,767	0.114985	646,395	74,326	90.00
91.00	Nursing School cost	0	2,292,767	0.000000	646,395	0	91.00
92.00	Allied health cost	0	2,292,767	0.000000	646,395	0	92.00
93.00	All other Medical Education	0	2,292,767	0.000000	646,395	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/25/2019 3:08 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,245	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,081	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)	730	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	92	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)	72	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)	22	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,292,767	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)	302,019	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,990,748	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)	1,990,748	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)	1,841.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	40,515	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)	40,515	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/25/2019 3:08 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	40,823	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	81,338	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)	351	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,841.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	646,395	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/25/2019 3:08 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	263,633	2,292,767	0.114985	646,395	74,326	90.00
91.00	Nursing School cost	0	2,292,767	0.000000	646,395	0	91.00
92.00	Allied health cost	0	2,292,767	0.000000	646,395	0	92.00
93.00	All other Medical Education	0	2,292,767	0.000000	646,395	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-3 | Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		497,846		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0		35.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.206513	261,980	54,102	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131881	100,013	13,190	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.181588	215,277	39,092	60.00
65.00	06500	RESPIRATORY THERAPY	0.473610	218,527	103,497	65.00
66.00	06600	PHYSICAL THERAPY	0.441963	45,397	20,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388629	12,721	4,944	67.00
68.00	06800	SPEECH PATHOLOGY	0.357531	9,036	3,231	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.228945	138,137	31,626	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3.646882	1,352	4,931	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.391530	246,551	96,532	73.00
76.00	03610	SLEEP LAB	0.327230	0	0	76.00
76.01	03480	ONCOLOGY	0.243147	203	49	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.557538	3,280	1,829	90.00
91.00	09100	EMERGENCY	0.302554	136	41	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.255602	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,252,610	373,128	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,252,610		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1308 | Component CCN: 15-Z308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-3 | Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0		35.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.206513	2,226	460	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131881	25,478	3,360	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.181588	35,071	6,368	60.00
65.00	06500	RESPIRATORY THERAPY	0.473610	22,128	10,480	65.00
66.00	06600	PHYSICAL THERAPY	0.441963	29,457	13,019	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388629	8,282	3,219	67.00
68.00	06800	SPEECH PATHOLOGY	0.357531	2,555	913	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.228945	7,326	1,677	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3.646882	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.391530	107,039	41,909	73.00
76.00	03610	SLEEP LAB	0.327230	0	0	76.00
76.01	03480	ONCOLOGY	0.243147	132	32	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.557538	2,128	1,186	90.00
91.00	09100	EMERGENCY	0.302554	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.255602	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		241,822	82,623	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)		241,822		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-3 | Date/Time Prepared: 11/25/2019 3:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		48,963		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0		35.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.206513	21,782	4,498	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131881	26,094	3,441	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.181588	36,469	6,622	60.00
65.00	06500	RESPIRATORY THERAPY	0.473610	16,788	7,951	65.00
66.00	06600	PHYSICAL THERAPY	0.441963	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388629	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.357531	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.228945	8,157	1,868	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3.646882	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.391530	20,031	7,843	73.00
76.00	03610	SLEEP LAB	0.327230	0	0	76.00
76.01	03480	ONCOLOGY	0.243147	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.557538	0	0	90.00
91.00	09100	EMERGENCY	0.302554	28,425	8,600	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.255602	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		157,746	40,823	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)		157,746		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/25/2019 3:08 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,846,627	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,846,627	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,905,093	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	33,590	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,477,310	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)	2,394,193	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)	2,394,193	30.00
31.00	Primary payer payments	313	31.00
32.00	Subtotal (line 30 minus line 31)	2,393,880	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)	858,358	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	557,933	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	775,428	36.00
37.00	Subtotal (see instructions)	2,951,813	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,951,813	40.00
40.01	Sequestration adjustment (see instructions)	59,036	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,824,919	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	67,858	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: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E-1 Part I Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		893,463		2,824,919	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)		893,463		2,824,919	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		67,858	6.01
6.02	SETTLEMENT TO PROGRAM		22,245		0	6.02
7.00	Total Medicare program liability (see instructions)		871,218		2,892,777	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1308 | Component CCN: 15-Z308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E-1 Part I | Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		286,039		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		286,039		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		20,270		0	6.02
7.00	Total Medicare program liability (see instructions)		265,769		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet E-1 Part II Date/Time Prepared: 11/25/2019 3:08 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1308 | Component CCN: 15-Z308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E-2 | Date/Time Prepared: 11/25/2019 3:08 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	193,439	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	83,449	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	104	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	276,888	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	276,888	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	276,888	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,695	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	271,193	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	271,193	0	19.00
19.01	Sequestration adjustment (see instructions)	5,424	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	286,039	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-20,270	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part V Date/Time Prepared: 11/25/2019 3:08 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	980,849	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	980,849	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	990,657	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	990,657	19.00
20.00	Deductibles (exclude professional component)	105,432	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	885,225	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	885,225	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	5,805	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	3,773	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,340	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	888,998	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	888,998	30.00
30.01	Sequestration adjustment (see instructions)	17,780	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	893,463	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-22,245	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 11/25/2019 3:08 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	81,338		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	81,338	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	81,338	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	48,963		8.00
9.00	Ancillary service charges	157,746	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	206,709	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	206,709	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	125,371	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	81,338	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	81,338	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	81,338	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	81,338	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	81,338	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	81,338	0	40.00
41.00	Interim payments	81,338	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G | Date/Time Prepared: 11/25/2019 3:08 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	70,372	47,293	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,739,027	0	0	0	4.00
5.00	Other receivable	1,097,320	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,777,582	0	0	0	6.00
7.00	Inventory	323,464	0	0	0	7.00
8.00	Prepaid expenses	172,724	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)	4,625,325	47,293	0	0	11.00
	FIXED ASSETS					
12.00	Land	457,300	0	0	0	12.00
13.00	Land improvements	528,489	0	0	0	13.00
14.00	Accumulated depreciation	-388,093	0	0	0	14.00
15.00	Buildings	13,353,069	0	0	0	15.00
16.00	Accumulated depreciation	-7,704,662	0	0	0	16.00
17.00	Leasehold improvements	9,743,578	0	0	0	17.00
18.00	Accumulated depreciation	-5,014,514	0	0	0	18.00
19.00	Fixed equipment	3,471,205	0	0	0	19.00
20.00	Accumulated depreciation	-2,343,917	0	0	0	20.00
21.00	Automobiles and trucks	14,695	0	0	0	21.00
22.00	Accumulated depreciation	-14,695	0	0	0	22.00
23.00	Major movable equipment	6,798,008	0	0	0	23.00
24.00	Accumulated depreciation	-5,262,583	0	0	0	24.00
25.00	Minor equipment depreciable	146,521	0	0	0	25.00
26.00	Accumulated depreciation	-120,934	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)	13,663,467	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	18,288,792	47,293	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	856,433	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,156,219	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	3,862,507	0	0	0	43.00
44.00	Other current liabilities	970,607	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,845,766	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,579,795	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)	10,579,795	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,425,561	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	863,231				52.00
53.00	Specific purpose fund		47,293			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)	863,231	47,293	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,288,792	47,293	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G-1 | Date/Time Prepared: 11/25/2019 3:08 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-1,557,892		35,260		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,352,902				2.00
3.00	Total (sum of line 1 and line 2)		795,010		35,260		3.00
4.00	TRANSFER FROM AFFILIATES	68,221		0		0	4.00
5.00	DONATIONS	0		0		0	5.00
6.00	RELEASED CAPITAL	0		0		0	6.00
7.00	RELEASED OPERATING	0		11		0	7.00
8.00	OTHER	0		12,022		0	8.00
9.00	ROUNDING	0		0		0	9.00
10.00	Total additions (sum of line 4-9)		68,221		12,033		10.00
11.00	Subtotal (line 3 plus line 10)		863,231		47,293		11.00
12.00	TRANSFERS FROM AFFILIATES	0		0		0	12.00
13.00	DEFERRED PENSION COST	0		0		0	13.00
14.00	OTHER	0		0		0	14.00
15.00	RELEASED CAPITAL	0		0		0	15.00
16.00	RELEASED OPERATING	0		0		0	16.00
17.00	ROUNDING	0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		863,231		47,293		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1308 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/25/2019 3:08 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,940,338		1,940,338	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)	1,940,338		1,940,338	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	DETOXIFICATION INTENSIVE CARE UNIT	0		0	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)	1,940,338		1,940,338	17.00
18.00	Ancillary services	3,780,696	51,753,316	55,534,012	18.00
19.00	Outpatient services	197,337	16,353,203	16,550,540	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,918,371	68,106,519	74,024,890	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,857,292		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)		22,857,292		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1308	Period: From 07/01/2018 To 06/30/2019	Worksheet G-3 Date/Time Prepared: 11/25/2019 3:08 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	74,024,890	1.00
2.00	Less contractual allowances and discounts on patients' accounts	48,942,264	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,082,626	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,857,292	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,225,334	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,659	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	44,544	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	1,175	17.00
18.00	Revenue from sale of medical records and abstracts	6,167	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	56,932	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC	14,641	24.00
24.01	NET ASSETS RELEASED FROM RESTRICTION	2,450	24.01
24.02	STATE PROGRAM REVENUE	0	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	OTHER (SPECIFY)	0	24.04
25.00	Total other income (sum of lines 6-24)	127,568	25.00
26.00	Total (line 5 plus line 25)	2,352,902	26.00
27.00	OTHER RECURRING	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,352,902	29.00