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: 15-2020	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/18/2019 1:33 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/18/2019 Time: 1:33 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 SETON SPECIALITY HOSPITAL (15-2020) 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	-229,721	56	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-229,721	56	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2019 1:33 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8050 TOWNSHIP LINE ROAD	PO Box:			1.00
2.00	City: INDIANAPOLIS	State: IN	Zip Code: 46260	County: MARION	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 SETON SPECIALITY HOSPITAL	152020	26900	2	02/08/2003	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2018	06/30/2019	20.00
21.00	Type of Control (see instructions)	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: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2019 1:33 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.				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: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 11/18/2019 1:33 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: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2019 1:33 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: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2019 1:33 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.	Y	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	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	N	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	N	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	N	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	N	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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.					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: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2019 1:33 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:	0	0	121,906	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.	N		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.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15HO46	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 11/18/2019 1:33 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	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	N	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.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part II | Date/Time Prepared: 11/18/2019 1:33 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	09/24/2019	Y	09/24/2019	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part II Date/Time Prepared: 11/18/2019 1:33 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.	N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KATHY	ZAMBOS	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3968	KATHY.ZAMBOS@ASCENSION.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-2020	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/18/2019 1:33 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.	LEAD ANALYST		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: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 11/18/2019 1:33 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	72	26,280	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		72	26,280	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		72	26,280	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		72				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: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 11/18/2019 1:33 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)	6,446	22	12,870			1.00
2.00	HMO and other (see instructions)	1,751	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,446	22	12,870			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	6,446	22	12,870	0.00	138.85	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	138.85	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			217			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	66					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 11/18/2019 1:33 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	176	1	345	1.00
2.00	HMO and other (see instructions)			48	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	176	1	345	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			3			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A | Date/Time Prepared: 11/18/2019 1:33 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		712,952	712,952	-182	712,770	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		315,144	315,144	0	315,144	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	103,443	2,082,919	2,186,362	0	2,186,362	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	382,062	8,031,219	8,413,281	182	8,413,463	5.00
7.00	00700	OPERATION OF PLANT	0	1,047,088	1,047,088	0	1,047,088	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	56,001	56,001	0	56,001	8.00
9.00	00900	HOUSEKEEPING	0	342,631	342,631	0	342,631	9.00
10.00	01000	DIETARY	0	623,209	623,209	0	623,209	10.00
13.00	01300	NURSING ADMINISTRATION	562,302	105,370	667,672	0	667,672	13.00
15.00	01500	PHARMACY	968,896	203,239	1,172,135	0	1,172,135	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01851	PASTORAL CARE	0	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,197,650	1,154,564	7,352,214	0	7,352,214	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,320	71,244	125,564	0	125,564	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,596	43,849	92,445	0	92,445	54.00
54.01	03630	ULTRA SOUND	7,794	721	8,515	0	8,515	54.01
57.00	05700	CT SCAN	920	70	990	0	990	57.00
60.00	06000	LABORATORY	5,576	232,300	237,876	0	237,876	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,666,748	150,889	1,817,637	0	1,817,637	65.00
66.00	06600	PHYSICAL THERAPY	266,413	20,938	287,351	0	287,351	66.00
67.00	06700	OCCUPATIONAL THERAPY	214,075	17,215	231,290	0	231,290	67.00
68.00	06800	SPEECH PATHOLOGY	164,739	13,072	177,811	0	177,811	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,504	110	1,614	0	1,614	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	856,385	856,385	0	856,385	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,055,355	1,055,355	0	1,055,355	73.00
74.00	07400	RENAL DIALYSIS	0	367,550	367,550	0	367,550	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,645,038	17,504,034	28,149,072	0	28,149,072	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	0	4,275	4,275	0	4,275	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	10,645,038	17,508,309	28,153,347	0	28,153,347	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A | Date/Time Prepared: 11/18/2019 1:33 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	712,770		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	315,144		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,782,312	3,968,674		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,503,571	3,909,892		5.00
7.00	00700	OPERATION OF PLANT	0	1,047,088		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	56,001		8.00
9.00	00900	HOUSEKEEPING	0	342,631		9.00
10.00	01000	DIETARY	-77,154	546,055		10.00
13.00	01300	NURSING ADMINISTRATION	-392	667,280		13.00
15.00	01500	PHARMACY	0	1,172,135		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
18.00	01851	PASTORAL CARE	0	0		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	7,352,214		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	125,564		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	92,445		54.00
54.01	03630	ULTRA SOUND	0	8,515		54.01
57.00	05700	CT SCAN	0	990		57.00
60.00	06000	LABORATORY	0	237,876		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	1,817,637		65.00
66.00	06600	PHYSICAL THERAPY	0	287,351		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	231,290		67.00
68.00	06800	SPEECH PATHOLOGY	0	177,811		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,614		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	856,385		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,055,355		73.00
74.00	07400	RENAL DIALYSIS	0	367,550		74.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,798,805	25,350,267		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	BIOTERRORISM GRANT	0	4,275		194.00
194.01	07951	MARKETING	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,798,805	25,354,542		200.00

RECLASSIFICATIONS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-6 | Date/Time Prepared: 11/18/2019 1:33 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	C - NON-CAPITAL INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	182		1.00
	TOTALS		0	182		
500.00	Grand Total: Increases		0	182		500.00

RECLASSIFICATIONS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-6 | Date/Time Prepared: 11/18/2019 1:33 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	C - NON-CAPITAL INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	182	11		1.00
	TOTALS		0	182			
500.00	Grand Total: Decreases		0	182			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-7 Part I Date/Time Prepared: 11/18/2019 1:33 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	847,629	0	0	0	0	1.00
2.00	Land Improvements	3,157	0	0	0	0	2.00
3.00	Buildings and Fixtures	15,952,903	33,000	0	33,000	0	3.00
4.00	Building Improvements	166,523	260,607	0	260,607	0	4.00
5.00	Fixed Equipment	984,867	0	0	0	0	5.00
6.00	Movable Equipment	5,242,423	44,600	0	44,600	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	23,197,502	338,207	0	338,207	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	23,197,502	338,207	0	338,207	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	847,629	0	1.00
2.00	Land Improvements	3,157	0	2.00
3.00	Buildings and Fixtures	15,985,903	0	3.00
4.00	Building Improvements	427,130	0	4.00
5.00	Fixed Equipment	984,867	0	5.00
6.00	Movable Equipment	5,287,023	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	23,535,709	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	23,535,709	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-7 Part II Date/Time Prepared: 11/18/2019 1:33 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	689,602	0	23,350	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	315,144	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,004,746	0	23,350	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	CAP REL COSTS-BLDG & FIXT	0	712,952	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	315,144	2.00
3.00	Total (sum of lines 1-2)	0	1,028,096	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-7 Part III Date/Time Prepared: 11/18/2019 1:33 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	17,104,292	0	17,104,292	0.773499	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,008,593	0	5,008,593	0.226501	0	2.00
3.00	Total (sum of lines 1-2)	22,112,885	0	22,112,885	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	689,602	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	315,144	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,004,746	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	23,168	0	0	0	712,770	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	315,144	2.00
3.00	Total (sum of lines 1-2)	23,168	0	0	0	1,027,914	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8 | Date/Time Prepared: 11/18/2019 1:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-15,120	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-7,230	ADMINISTRATIVE & GENERAL	5.00	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			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	-2,691,240			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-74,674	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-2,480	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-5,025	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8 | Date/Time Prepared: 11/18/2019 1:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	LATE PENALTY FEE	A	-520	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	LOBBYING OFFSET	A	-459	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ENTERTAINMENT	A	-705	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	ENTERTAINMENT	A	-392	NURSING ADMINISTRATION	13.00	0	33.04
33.05	CHARITY EXPENSE	A	-960	ADMINISTRATIVE & GENERAL	5.00	0	33.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,798,805				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: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8-1 | Date/Time Prepared: 11/18/2019 1:33 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	505,468	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE OTHER	3,230,992	8,232,362	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST	7,122	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	1,782,312	0	3.01
3.02	7.00	OPERATION OF PLANT	SVH CHARGEBACK	87,721	87,721	3.02
3.03	13.00	NURSING ADMINISTRATION	SVH CHARGEBACK	104,514	104,514	3.03
3.04	15.00	PHARMACY	SVH CHARGEBACK	21,552	21,552	3.04
3.05	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	37,719	37,719	3.05
3.06	66.00	PHYSICAL THERAPY	SVH CHARGEBACK	12,195	12,195	3.06
3.07	67.00	OCCUPATIONAL THERAPY	SVH CHAGEBACK	12,195	12,195	3.07
3.08	68.00	SPEECH PATHOLOGY	SVH CHARGEBACK	12,195	12,195	3.08
3.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACK	130,714	130,714	3.10
3.11	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	15,120	0	3.11
3.13	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	108	0	3.13
3.14	0.00			0	0	3.14
4.00	0.00			0	0	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,959,927	8,651,167	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	G	ST VINCENT HEAL	100.00		0.00	6.00
7.00	G	ASCENSION	100.00		0.00	7.00
8.00	A	MEDXCEL	100.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8-1 | Date/Time Prepared: 11/18/2019 1:33 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	505,468	0		1.00
2.00	-5,001,370	0		2.00
3.00	7,122	0		3.00
3.01	1,782,312	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.10	0	0		3.10
3.11	15,120	11		3.11
3.13	108	11		3.13
3.14	0	0		3.14
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
5.00	-2,691,240			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			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I Date/Time Prepared: 11/18/2019 1:33 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	712,770	712,770				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	315,144		315,144			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,968,674	0	0	3,968,674		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,909,892	48,511	21,449	143,838	4,123,690	5.00
7.00	00700	OPERATION OF PLANT	1,047,088	35,715	15,791	0	1,098,594	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56,001	5,830	2,578	0	64,409	8.00
9.00	00900	HOUSEKEEPING	342,631	8,099	3,581	0	354,311	9.00
10.00	01000	DIETARY	546,055	28,908	12,782	0	587,745	10.00
13.00	01300	NURSING ADMINISTRATION	667,280	36,275	16,039	211,694	931,288	13.00
15.00	01500	PHARMACY	1,172,135	16,974	7,505	364,768	1,561,382	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,712	3,410	0	11,122	16.00
17.00	01700	SOCIAL SERVICE	0	4,236	1,873	0	6,109	17.00
18.00	01851	PASTORAL CARE	0	5,227	2,311	0	7,538	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,352,214	477,731	211,222	2,333,275	10,374,442	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	125,564	5,112	2,260	20,450	153,386	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,445	9,191	4,064	18,295	123,995	54.00
54.01	03630	ULTRA SOUND	8,515	0	0	2,934	11,449	54.01
57.00	05700	CT SCAN	990	2,441	1,079	346	4,856	57.00
60.00	06000	LABORATORY	237,876	1,996	883	2,099	242,854	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,817,637	3,619	1,600	627,494	2,450,350	65.00
66.00	06600	PHYSICAL THERAPY	287,351	5,069	2,241	100,299	394,960	66.00
67.00	06700	OCCUPATIONAL THERAPY	231,290	5,069	2,241	80,595	319,195	67.00
68.00	06800	SPEECH PATHOLOGY	177,811	5,055	2,235	62,021	247,122	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,614	0	0	566	2,180	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	856,385	0	0	0	856,385	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,055,355	0	0	0	1,055,355	73.00
74.00	07400	RENAL DIALYSIS	367,550	0	0	0	367,550	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,350,267	712,770	315,144	3,968,674	25,350,267	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	4,275	0	0	0	4,275	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	25,354,542	712,770	315,144	3,968,674	25,354,542	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I | Date/Time Prepared: 11/18/2019 1:33 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,123,690					5.00
7.00	00700	OPERATION OF PLANT	213,381	1,311,975				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,510	12,170	89,089			8.00
9.00	00900	HOUSEKEEPING	68,818	16,906	0	440,035		9.00
10.00	01000	DIETARY	114,158	60,341	0	20,697	782,941	10.00
13.00	01300	NURSING ADMINISTRATION	180,885	75,719	0	25,972	0	13.00
15.00	01500	PHARMACY	303,269	35,431	0	12,153	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,160	16,097	0	5,521	0	16.00
17.00	01700	SOCIAL SERVICE	1,187	8,843	0	3,033	0	17.00
18.00	01851	PASTORAL CARE	1,464	10,911	0	3,743	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,015,038	997,172	89,089	342,031	782,941	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,792	10,671	0	3,660	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,084	19,184	0	6,580	0	54.00
54.01	03630	ULTRA SOUND	2,224	0	0	0	0	54.01
57.00	05700	CT SCAN	943	5,096	0	1,748	0	57.00
60.00	06000	LABORATORY	47,170	4,167	0	1,429	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	475,934	7,554	0	2,591	0	65.00
66.00	06600	PHYSICAL THERAPY	76,713	10,581	0	3,629	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,998	10,581	0	3,629	0	67.00
68.00	06800	SPEECH PATHOLOGY	47,999	10,551	0	3,619	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	423	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	166,337	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	204,983	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	71,390	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,122,860	1,311,975	89,089	440,035	782,941	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	830	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,123,690	1,311,975	89,089	440,035	782,941	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I Date/Time Prepared: 11/18/2019 1:33 pm

		Cost Center Description	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PASTORAL CARE	
			13.00	15.00	16.00	17.00	18.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	1,213,864					13.00
15.00	01500	PHARMACY	0	1,912,235				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	34,900			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	19,172		17.00
18.00	01851	PASTORAL CARE	0	0	0	0	23,656	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	868,732	0	14,731	19,172	23,656	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,018	0	482	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	515	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	108	0	0	54.01
57.00	05700	CT SCAN	0	0	111	0	0	57.00
60.00	06000	LABORATORY	0	0	3,365	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	249,018	0	8,694	0	0	65.00
66.00	06600	PHYSICAL THERAPY	37,954	0	349	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,115	0	652	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	22,027	0	289	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	5	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	754	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,912,235	4,153	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	692	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,213,864	1,912,235	34,900	19,172	23,656	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,213,864	1,912,235	34,900	19,172	23,656	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I Date/Time Prepared: 11/18/2019 1:33 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
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
18.00	01851	PASTORAL CARE					18.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	15,527,004	0	15,527,004		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	204,009	0	204,009		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	174,358	0	174,358		54.00
54.01	03630	ULTRA SOUND	13,781	0	13,781		54.01
57.00	05700	CT SCAN	12,754	0	12,754		57.00
60.00	06000	LABORATORY	298,985	0	298,985		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	3,194,141	0	3,194,141		65.00
66.00	06600	PHYSICAL THERAPY	524,186	0	524,186		66.00
67.00	06700	OCCUPATIONAL THERAPY	426,170	0	426,170		67.00
68.00	06800	SPEECH PATHOLOGY	331,607	0	331,607		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,608	0	2,608		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,023,476	0	1,023,476		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,176,726	0	3,176,726		73.00
74.00	07400	RENAL DIALYSIS	439,632	0	439,632		74.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,349,437	0	25,349,437		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	BIOTERRORISM GRANT	5,105	0	5,105		194.00
194.01	07951	MARKETING	0	0	0		194.01
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)	25,354,542	0	25,354,542		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II | Date/Time Prepared: 11/18/2019 1:33 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	505,468	48,511	21,449	575,428	0	5.00
7.00	00700	OPERATION OF PLANT	0	35,715	15,791	51,506	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,830	2,578	8,408	0	8.00
9.00	00900	HOUSEKEEPING	0	8,099	3,581	11,680	0	9.00
10.00	01000	DIETARY	0	28,908	12,782	41,690	0	10.00
13.00	01300	NURSING ADMINISTRATION	0	36,275	16,039	52,314	0	13.00
15.00	01500	PHARMACY	0	16,974	7,505	24,479	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,712	3,410	11,122	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,236	1,873	6,109	0	17.00
18.00	01851	PASTORAL CARE	0	5,227	2,311	7,538	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	477,731	211,222	688,953	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,112	2,260	7,372	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,191	4,064	13,255	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	2,441	1,079	3,520	0	57.00
60.00	06000	LABORATORY	0	1,996	883	2,879	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,619	1,600	5,219	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,069	2,241	7,310	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,069	2,241	7,310	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,055	2,235	7,290	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	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	505,468	712,770	315,144	1,533,382	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	505,468	712,770	315,144	1,533,382	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II | Date/Time Prepared: 11/18/2019 1:33 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	575,428					5.00
7.00	00700	OPERATION OF PLANT	29,775	81,281				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,746	754	10,908			8.00
9.00	00900	HOUSEKEEPING	9,603	1,047	0	22,330		9.00
10.00	01000	DIETARY	15,930	3,738	0	1,050	62,408	10.00
13.00	01300	NURSING ADMINISTRATION	25,241	4,691	0	1,318	0	13.00
15.00	01500	PHARMACY	42,318	2,195	0	617	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	301	997	0	280	0	16.00
17.00	01700	SOCIAL SERVICE	166	548	0	154	0	17.00
18.00	01851	PASTORAL CARE	204	676	0	190	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	281,185	61,777	10,908	17,356	62,408	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,157	661	0	186	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,361	1,189	0	334	0	54.00
54.01	03630	ULTRA SOUND	310	0	0	0	0	54.01
57.00	05700	CT SCAN	132	316	0	89	0	57.00
60.00	06000	LABORATORY	6,582	258	0	73	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	66,412	468	0	131	0	65.00
66.00	06600	PHYSICAL THERAPY	10,705	656	0	184	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,651	656	0	184	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,698	654	0	184	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	59	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,211	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,603	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	9,962	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	575,312	81,281	10,908	22,330	62,408	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	116	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	575,428	81,281	10,908	22,330	62,408	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II Date/Time Prepared: 11/18/2019 1:33 pm

		Cost Center Description	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PASTORAL CARE	
			13.00	15.00	16.00	17.00	18.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	83,564					13.00
15.00	01500	PHARMACY	0	69,609				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	12,700			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	6,977		17.00
18.00	01851	PASTORAL CARE	0	0	0	0	8,608	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,805	0	5,367	6,977	8,608	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	414	0	175	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	187	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	39	0	0	54.01
57.00	05700	CT SCAN	0	0	40	0	0	57.00
60.00	06000	LABORATORY	0	0	1,224	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	17,143	0	3,161	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,613	0	127	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,073	0	237	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,516	0	105	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	274	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	69,609	1,510	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	252	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,564	69,609	12,700	6,977	8,608	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	83,564	69,609	12,700	6,977	8,608	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II Date/Time Prepared: 11/18/2019 1:33 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
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
18.00	01851	PASTORAL CARE					18.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,203,344	0	1,203,344		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	12,965	0	12,965		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,326	0	18,326		54.00
54.01	03630	ULTRA SOUND	349	0	349		54.01
57.00	05700	CT SCAN	4,097	0	4,097		57.00
60.00	06000	LABORATORY	11,016	0	11,016		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	92,534	0	92,534		65.00
66.00	06600	PHYSICAL THERAPY	21,595	0	21,595		66.00
67.00	06700	OCCUPATIONAL THERAPY	19,111	0	19,111		67.00
68.00	06800	SPEECH PATHOLOGY	16,447	0	16,447		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	61	0	61		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,485	0	23,485		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	99,722	0	99,722		73.00
74.00	07400	RENAL DIALYSIS	10,214	0	10,214		74.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,533,266	0	1,533,266		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	BIOTERRORISM GRANT	116	0	116		194.00
194.01	07951	MARKETING	0	0	0		194.01
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)	1,533,382	0	1,533,382		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B-1 | Date/Time Prepared: 11/18/2019 1:33 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	49,633					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		49,633				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,541,595			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,378	3,378	382,062	-4,123,690	21,230,852	5.00
7.00	00700	OPERATION OF PLANT	2,487	2,487	0	0	1,098,594	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	406	406	0	0	64,409	8.00
9.00	00900	HOUSEKEEPING	564	564	0	0	354,311	9.00
10.00	01000	DIETARY	2,013	2,013	0	0	587,745	10.00
13.00	01300	NURSING ADMINISTRATION	2,526	2,526	562,302	0	931,288	13.00
15.00	01500	PHARMACY	1,182	1,182	968,896	0	1,561,382	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	537	537	0	0	11,122	16.00
17.00	01700	SOCIAL SERVICE	295	295	0	0	6,109	17.00
18.00	01851	PASTORAL CARE	364	364	0	0	7,538	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,266	33,266	6,197,650	0	10,374,442	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	356	356	54,320	0	153,386	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	640	640	48,596	0	123,995	54.00
54.01	03630	ULTRA SOUND	0	0	7,794	0	11,449	54.01
57.00	05700	CT SCAN	170	170	920	0	4,856	57.00
60.00	06000	LABORATORY	139	139	5,576	0	242,854	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	252	252	1,666,748	0	2,450,350	65.00
66.00	06600	PHYSICAL THERAPY	353	353	266,413	0	394,960	66.00
67.00	06700	OCCUPATIONAL THERAPY	353	353	214,075	0	319,195	67.00
68.00	06800	SPEECH PATHOLOGY	352	352	164,739	0	247,122	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	1,504	0	2,180	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	856,385	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,055,355	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	367,550	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,633	49,633	10,541,595	-4,123,690	21,226,577	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	0	0	0	0	4,275	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	712,770	315,144	3,968,674		4,123,690	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.360808	6.349485	0.376478		0.194231	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		575,428	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.027103	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: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B-1 | Date/Time Prepared: 11/18/2019 1:33 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	43,768					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	406	100				8.00
9.00	00900	HOUSEKEEPING	564	0	42,798			9.00
10.00	01000	DIETARY	2,013	0	2,013	12,870		10.00
13.00	01300	NURSING ADMINISTRATION	2,526	0	2,526	0	239,226	13.00
15.00	01500	PHARMACY	1,182	0	1,182	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	537	0	537	0	0	16.00
17.00	01700	SOCIAL SERVICE	295	0	295	0	0	17.00
18.00	01851	PASTORAL CARE	364	0	364	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,266	100	33,266	12,870	171,208	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	356	0	356	0	1,186	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	640	0	640	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	170	0	170	0	0	57.00
60.00	06000	LABORATORY	139	0	139	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	252	0	252	0	49,076	65.00
66.00	06600	PHYSICAL THERAPY	353	0	353	0	7,480	66.00
67.00	06700	OCCUPATIONAL THERAPY	353	0	353	0	5,935	67.00
68.00	06800	SPEECH PATHOLOGY	352	0	352	0	4,341	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	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,768	100	42,798	12,870	239,226	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,311,975	89,089	440,035	782,941	1,213,864	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.975667	890.890000	10.281672	60.834577	5.074131	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	81,281	10,908	22,330	62,408	83,564	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.857087	109.080000	0.521753	4.849106	0.349310	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: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B-1 | Date/Time Prepared: 11/18/2019 1:33 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	OTHER GENERAL SERVICE PASTORAL CARE (TOTAL PATIENT DAYS)		
			15.00	16.00	17.00	18.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY	1,000					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	90,546,120				16.00
17.00	01700	SOCIAL SERVICE	0	0	12,870			17.00
18.00	01851	PASTORAL CARE	0	0	0	12,870		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	38,156,332	12,870	12,870		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,252,840	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,337,258	0	0		54.00
54.01	03630	ULTRA SOUND	0	279,819	0	0		54.01
57.00	05700	CT SCAN	0	288,936	0	0		57.00
60.00	06000	LABORATORY	0	8,740,663	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	22,581,178	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	906,733	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,694,512	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	750,644	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	12,372	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,958,740	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,000	10,787,775	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	1,798,318	0	0		74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,000	90,546,120	12,870	12,870		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	BIOTERRORISM GRANT	0	0	0	0		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,912,235	34,900	19,172	23,656		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,912.235000	0.000385	1.489666	1.838073		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	69,609	12,700	6,977	8,608		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	69.609000	0.000140	0.542113	0.668842		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: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/18/2019 1:33 pm

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		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	15,527,004		15,527,004	0	15,527,004	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	204,009		204,009	0	204,009	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	174,358		174,358	0	174,358	54.00
54.01	03630	ULTRA SOUND	13,781		13,781	0	13,781	54.01
57.00	05700	CT SCAN	12,754		12,754	0	12,754	57.00
60.00	06000	LABORATORY	298,985		298,985	0	298,985	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,194,141	0	3,194,141	0	3,194,141	65.00
66.00	06600	PHYSICAL THERAPY	524,186	0	524,186	0	524,186	66.00
67.00	06700	OCCUPATIONAL THERAPY	426,170	0	426,170	0	426,170	67.00
68.00	06800	SPEECH PATHOLOGY	331,607	0	331,607	0	331,607	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,608		2,608	0	2,608	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,023,476		1,023,476	0	1,023,476	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,176,726		3,176,726	0	3,176,726	73.00
74.00	07400	RENAL DIALYSIS	439,632		439,632	0	439,632	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,349,437	0	25,349,437	0	25,349,437	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	25,349,437	0	25,349,437	0	25,349,437	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/18/2019 1:33 pm

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		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	38,156,332		38,156,332			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,243,706	9,134	1,252,840	0.162837	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,334,040	3,218	1,337,258	0.130385	0.000000	54.00
54.01	03630	ULTRA SOUND	276,765	3,054	279,819	0.049250	0.000000	54.01
57.00	05700	CT SCAN	288,086	850	288,936	0.044141	0.000000	57.00
60.00	06000	LABORATORY	8,740,663	0	8,740,663	0.034206	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	22,532,866	48,312	22,581,178	0.141451	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	906,733	0	906,733	0.578104	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,694,512	0	1,694,512	0.251500	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	750,644	0	750,644	0.441763	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,372	0	12,372	0.210799	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,948,965	9,775	1,958,740	0.522518	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,757,211	30,564	10,787,775	0.294475	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,798,318	0	1,798,318	0.244468	0.000000	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	90,441,213	104,907	90,546,120			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	90,441,213	104,907	90,546,120			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/18/2019 1:33 pm

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.162837		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.130385		54.00
54.01	03630	ULTRA SOUND	0.049250		54.01
57.00	05700	CT SCAN	0.044141		57.00
60.00	06000	LABORATORY	0.034206		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.141451		65.00
66.00	06600	PHYSICAL THERAPY	0.578104		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.251500		67.00
68.00	06800	SPEECH PATHOLOGY	0.441763		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.210799		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.522518		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294475		73.00
74.00	07400	RENAL DIALYSIS	0.244468		74.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/18/2019 1:33 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	15,527,004		15,527,004	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	204,009		204,009	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	174,358		174,358	0	0	54.00
54.01	03630	ULTRA SOUND	13,781		13,781	0	0	54.01
57.00	05700	CT SCAN	12,754		12,754	0	0	57.00
60.00	06000	LABORATORY	298,985		298,985	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,194,141	0	3,194,141	0	0	65.00
66.00	06600	PHYSICAL THERAPY	524,186	0	524,186	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	426,170	0	426,170	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	331,607	0	331,607	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,608		2,608	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,023,476		1,023,476	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,176,726		3,176,726	0	0	73.00
74.00	07400	RENAL DIALYSIS	439,632		439,632	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,349,437	0	25,349,437	0	0	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	25,349,437	0	25,349,437	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/18/2019 1:33 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	38,156,332		38,156,332			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,243,706	9,134	1,252,840	0.162837	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,334,040	4,517	1,338,557	0.130258	0.000000	54.00
54.01	03630	ULTRA SOUND	276,765	1,755	278,520	0.049479	0.000000	54.01
57.00	05700	CT SCAN	288,086	850	288,936	0.044141	0.000000	57.00
60.00	06000	LABORATORY	8,332,915	0	8,332,915	0.035880	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	407,748	0	407,748	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	22,532,866	48,312	22,581,178	0.141451	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,558,359	0	1,558,359	0.336371	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,042,886	0	1,042,886	0.408645	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	750,644	0	750,644	0.441763	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,372	0	12,372	0.210799	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,948,965	9,775	1,958,740	0.522518	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,757,211	29,958	10,787,169	0.294491	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,798,318	0	1,798,318	0.244468	0.000000	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	90,441,213	104,301	90,545,514			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	90,441,213	104,301	90,545,514			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/18/2019 1:33 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRA SOUND	0.000000		54.01
57.00	05700	CT SCAN	0.000000		57.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
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	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part I Date/Time Prepared: 11/18/2019 1:33 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,203,344	0	1,203,344	12,870	93.50	30.00
200.00	Total (lines 30 through 199)	1,203,344		1,203,344	12,870		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	6,446	602,701	30.00
200.00	Total (lines 30 through 199)	6,446	602,701	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part II Date/Time Prepared: 11/18/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,965	1,252,840	0.010348	1,066,587	11,037	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,326	1,337,258	0.013704	408,092	5,592	54.00
54.01	03630	ULTRA SOUND	349	279,819	0.001247	263,622	329	54.01
57.00	05700	CT SCAN	4,097	288,936	0.014180	138,200	1,960	57.00
60.00	06000	LABORATORY	11,016	8,740,663	0.001260	5,049,478	6,362	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	92,534	22,581,178	0.004098	12,423,774	50,913	65.00
66.00	06600	PHYSICAL THERAPY	21,595	906,733	0.023816	660,544	15,732	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,111	1,694,512	0.011278	736,704	8,309	67.00
68.00	06800	SPEECH PATHOLOGY	16,447	750,644	0.021911	333,740	7,313	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	61	12,372	0.004930	4,456	22	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,485	1,958,740	0.011990	984,386	11,803	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	99,722	10,787,775	0.009244	5,267,072	48,689	73.00
74.00	07400	RENAL DIALYSIS	10,214	1,798,318	0.005680	916,902	5,208	74.00
200.00		Total (lines 50 through 199)	329,922	52,389,788		28,253,557	173,269	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part III Date/Time Prepared: 11/18/2019 1:33 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	12,870	0.00	6,446	30.00
200.00		Total (lines 30 through 199)		0	12,870		6,446	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV Date/Time Prepared: 11/18/2019 1:33 pm

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		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
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV Date/Time Prepared: 11/18/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,252,840	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,337,258	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	279,819	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	288,936	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	8,740,663	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	22,581,178	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	906,733	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,694,512	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	750,644	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	12,372	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,958,740	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,787,775	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,798,318	0.000000	74.00
200.00		Total (lines 50 through 199)	0	0	0	52,389,788		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV Date/Time Prepared: 11/18/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,066,587	0	9,134	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	408,092	0	3,218	0	54.00
54.01	03630	ULTRA SOUND	0.000000	263,622	0	3,054	0	54.01
57.00	05700	CT SCAN	0.000000	138,200	0	850	0	57.00
60.00	06000	LABORATORY	0.000000	5,049,478	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	12,423,774	0	48,312	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	660,544	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	736,704	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	333,740	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	4,456	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	984,386	0	9,775	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,267,072	0	29,958	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	916,902	0	0	0	74.00
200.00		Total (lines 50 through 199)		28,253,557	0	104,301	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V Date/Time Prepared: 11/18/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.162837	9,134	0	0	1,487	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.130385	3,218	0	0	420	54.00
54.01	03630	ULTRA SOUND	0.049250	3,054	0	0	150	54.01
57.00	05700	CT SCAN	0.044141	850	0	0	38	57.00
60.00	06000	LABORATORY	0.034206	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.141451	48,312	0	0	6,834	65.00
66.00	06600	PHYSICAL THERAPY	0.578104	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.251500	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.441763	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.210799	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.522518	9,775	0	0	5,108	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294475	29,958	0	606	8,822	73.00
74.00	07400	RENAL DIALYSIS	0.244468	0	0	0	0	74.00
200.00		Subtotal (see instructions)		104,301	0	606	22,859	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		104,301	0	606	22,859	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V Date/Time Prepared: 11/18/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
57.00	05700	CT SCAN	0	0	57.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
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	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	178	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
200.00		Subtotal (see instructions)	0	178	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	178	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part I Date/Time Prepared: 11/18/2019 1:33 pm

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,203,344	0	1,203,344	12,870	93.50	30.00
200.00	Total (lines 30 through 199)	1,203,344		1,203,344	12,870		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	22	2,057	30.00
200.00	Total (lines 30 through 199)	22	2,057	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part II Date/Time Prepared: 11/18/2019 1:33 pm

Title XIX | 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	12,965	1,252,840	0.010348	6,608	68	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,326	1,338,557	0.013691	31,159	427	54.00
54.01	03630	ULTRA SOUND	349	278,520	0.001253	10,635	13	54.01
57.00	05700	CT SCAN	4,097	288,936	0.014180	22,626	321	57.00
60.00	06000	LABORATORY	11,016	8,332,915	0.001322	349,696	462	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	407,748	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	92,534	22,581,178	0.004098	598,130	2,451	65.00
66.00	06600	PHYSICAL THERAPY	21,595	1,558,359	0.013858	91,789	1,272	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,111	1,042,886	0.018325	95,302	1,746	67.00
68.00	06800	SPEECH PATHOLOGY	16,447	750,644	0.021911	35,457	777	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	61	12,372	0.004930	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,485	1,958,740	0.011990	176,818	2,120	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	99,722	10,787,169	0.009245	586,837	5,425	73.00
74.00	07400	RENAL DIALYSIS	10,214	1,798,318	0.005680	0	0	74.00
200.00		Total (lines 50 through 199)	329,922	52,389,182		2,005,057	15,082	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part III Date/Time Prepared: 11/18/2019 1:33 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
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	12,870	0.00	22	30.00
200.00		Total (lines 30 through 199)		0	12,870		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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV Date/Time Prepared: 11/18/2019 1:33 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
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV Date/Time Prepared: 11/18/2019 1:33 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	1,252,840	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,338,557	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	278,520	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	288,936	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	8,332,915	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	407,748	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	22,581,178	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,558,359	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,042,886	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	750,644	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	12,372	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,958,740	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,787,169	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,798,318	0.000000	74.00
200.00		Total (lines 50 through 199)	0	0	0	52,389,182		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV Date/Time Prepared: 11/18/2019 1:33 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	6,608	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	31,159	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	10,635	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	22,626	0	0	0	57.00
60.00	06000	LABORATORY	0.000000	349,696	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	598,130	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	91,789	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	95,302	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	35,457	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	176,818	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	586,837	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
200.00		Total (lines 50 through 199)		2,005,057	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-2020	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/18/2019 1:33 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,870	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,870	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)	12,870	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	6,446	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	15,527,004	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,527,004	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)	15,527,004	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)	1,206.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,776,777	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)	7,776,777	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/18/2019 1:33 pm

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	5,181,099	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	12,957,876	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	602,701	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	173,269	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	775,970	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	12,181,906	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/18/2019 1:33 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,203,344	15,527,004	0.077500	0	0	90.00
91.00	Nursing School cost	0	15,527,004	0.000000	0	0	91.00
92.00	Allied health cost	0	15,527,004	0.000000	0	0	92.00
93.00	All other Medical Education	0	15,527,004	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/18/2019 1:33 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)	12,870	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,870	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)	12,870	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	15,527,004	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,527,004	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)	15,527,004	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)	1,206.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	26,542	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	26,542	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/18/2019 1:33 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						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	454,506	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	481,048	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/18/2019 1:33 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	1,203,344	15,527,004	0.077500	0	0	90.00
91.00	Nursing School cost	0	15,527,004	0.000000	0	0	91.00
92.00	Allied health cost	0	15,527,004	0.000000	0	0	92.00
93.00	All other Medical Education	0	15,527,004	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-3 | Date/Time Prepared: 11/18/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		18,368,080		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.162837	1,066,587	173,680	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.130385	408,092	53,209	54.00
54.01	03630	ULTRA SOUND	0.049250	263,622	12,983	54.01
57.00	05700	CT SCAN	0.044141	138,200	6,100	57.00
60.00	06000	LABORATORY	0.034206	5,049,478	172,722	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.141451	12,423,774	1,757,355	65.00
66.00	06600	PHYSICAL THERAPY	0.578104	660,544	381,863	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.251500	736,704	185,281	67.00
68.00	06800	SPEECH PATHOLOGY	0.441763	333,740	147,434	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.210799	4,456	939	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.522518	984,386	514,359	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294475	5,267,072	1,551,021	73.00
74.00	07400	RENAL DIALYSIS	0.244468	916,902	224,153	74.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		28,253,557	5,181,099	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)		28,253,557		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-3 | Date/Time Prepared: 11/18/2019 1:33 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		1,861,911		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.162837	6,608	1,076	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.130258	31,159	4,059	54.00
54.01	03630	ULTRA SOUND	0.049479	10,635	526	54.01
57.00	05700	CT SCAN	0.044141	22,626	999	57.00
60.00	06000	LABORATORY	0.035880	349,696	12,547	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.141451	598,130	84,606	65.00
66.00	06600	PHYSICAL THERAPY	0.336371	91,789	30,875	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.408645	95,302	38,945	67.00
68.00	06800	SPEECH PATHOLOGY	0.441763	35,457	15,664	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.210799	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.522518	176,818	92,391	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294491	586,837	172,818	73.00
74.00	07400	RENAL DIALYSIS	0.244468	0	0	74.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,005,057	454,506	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)		2,005,057		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-2020	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/18/2019 1:33 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	178	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	22,859	2.00
3.00	OPPS payments	7,506	3.00
4.00	Outlier payment (see instructions)	4,627	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)	178	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	606	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)	606	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)	606	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	428	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)	178	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	12,133	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,389	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	10,922	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	10,922	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	10,922	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	10,922	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	10,922	40.00
40.01	Sequestration adjustment (see instructions)	218	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	10,648	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	56	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: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E-1 Part I Date/Time Prepared: 11/18/2019 1:33 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		11,627,776		10,648	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	01/17/2019	122,700		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)		122,700		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)		11,750,476		10,648	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		56	6.01
6.02	SETTLEMENT TO PROGRAM		229,721		0	6.02
7.00	Total Medicare program liability (see instructions)		11,520,755		10,704	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	Provider CCN: 15-2020	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part IV Date/Time Prepared: 11/18/2019 1:33 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS		
1.00	Net Federal PPS Payments (see instructions)	10,331,838	1.00
1.01	Full standard payment amount	7,754,750	1.01
1.02	Short stay outlier standard payment amount	2,562,690	1.02
1.03	Site neutral payment amount - Cost	0	1.03
1.04	Site neutral payment amount - IPPS comparable	14,398	1.04
2.00	Outlier Payments	2,327,759	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)	12,659,597	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)	0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)	0	6.00
7.00	Subtotal (see instructions)	12,659,597	7.00
8.00	Primary payer payments	0	8.00
9.00	Subtotal (line 7 less line 8).	12,659,597	9.00
10.00	Deductibles	8,088	10.00
11.00	Subtotal (line 9 minus line 10)	12,651,509	11.00
12.00	Coinsurance	1,023,703	12.00
13.00	Subtotal (line 11 minus line 12)	11,627,806	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	197,024	14.00
15.00	Adjusted reimbursable bad debts (see instructions)	128,066	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	197,024	16.00
17.00	Subtotal (sum of lines 13 and 15)	11,755,872	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	18.00
19.00	Other pass through costs (see instructions)	0	19.00
20.00	Outlier payments reconciliation	0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	21.50
21.99	Demonstration payment adjustment amount before sequestration	0	21.99
22.00	Total amount payable to the provider (see instructions)	11,755,872	22.00
22.01	Sequestration adjustment (see instructions)	235,117	22.01
22.02	Demonstration payment adjustment amount after sequestration	0	22.02
23.00	Interim payments	11,750,476	23.00
24.00	Tentative settlement (for contractor use only)	0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)	-229,721	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	26.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)	2,327,759	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-2020	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 11/18/2019 1:33 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	481,048		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)	481,048	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)	481,048	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	81,113		8.00
9.00	Ancillary service charges	2,005,057	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)	2,086,170	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)	2,086,170	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,605,122	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)	481,048	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)	481,048	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)	481,048	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)	481,048	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	481,048	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)	481,048	0	40.00
41.00	Interim payments	481,048	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: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G | Date/Time Prepared: 11/18/2019 1:33 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	0	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	15,766,795	0	0	0	4.00
5.00	Other receivable	592,989	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,741,041	0	0	0	6.00
7.00	Inventory	356,922	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	2,111	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)	7,977,776	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	847,629	0	0	0	12.00
13.00	Land improvements	3,157	0	0	0	13.00
14.00	Accumulated depreciation	-3,157	0	0	0	14.00
15.00	Buildings	17,397,899	0	0	0	15.00
16.00	Accumulated depreciation	-10,086,283	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,287,024	0	0	0	23.00
24.00	Accumulated depreciation	-4,505,133	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	8,941,136	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)	16,918,912	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	376,863	0	0	0	37.00
38.00	Salaries, wages, and fees payable	500,970	0	0	0	38.00
39.00	Payroll taxes payable	327,292	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,956,145	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,161,270	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	391,595	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	391,595	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,552,865	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	12,366,047				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	12,366,047	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	16,918,912	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G-1 | Date/Time Prepared: 11/18/2019 1:33 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		12,553,357		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,539,766				2.00
3.00	Total (sum of line 1 and line 2)		16,093,123		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		16,093,123		0		11.00
12.00	TRANSFER OF INVESTMENTS TO HO	3,727,076		0		0	12.00
13.00	MISC	0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		3,727,076		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,366,047		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/18/2019 1:33 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	35,362,337		35,362,337	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)	35,362,337		35,362,337	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	35,362,337		35,362,337	17.00
18.00	Ancillary services	55,016,345	150,998	55,167,343	18.00
19.00	Outpatient services	0	15,835	15,835	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)	90,378,682	166,833	90,545,515	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,153,347		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)		28,153,347		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-2020 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G-3 | Date/Time Prepared: 11/18/2019 1:33 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	90,545,515	1.00
2.00	Less contractual allowances and discounts on patients' accounts	58,934,579	2.00
3.00	Net patient revenues (line 1 minus line 2)	31,610,936	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,153,347	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,457,589	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	74,674	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	2,480	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISCELLANEOUS REVENUE	5,023	24.00
24.01	OTHER (SPECIFY)	0	24.01
24.02	OTHER (SPECIFY)	0	24.02
25.00	Total other income (sum of lines 6-24)	82,177	25.00
26.00	Total (line 5 plus line 25)	3,539,766	26.00
27.00	BAD DEBT EXPENSE	0	27.00
27.01	NONOPERATING GAINS	0	27.01
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)	3,539,766	29.00