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: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/25/2019 8:07 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/25/2019 Time: 8:07 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT CARMEL HOSPITAL (15-0157) 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	148,747	77,387	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	148,747	77,387	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: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 8:07 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 13500 NORTH MERIDIAN STREET	PO Box:			1.00
2.00	City: CARMEL	State: IN	Zip Code: 46033	County: HAMILTON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. VINCENT CARMEL HOSPITAL	150157	26900	1	01/14/2004	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.	Y	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	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	522	290	0	6	2,621	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 8:07 am

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 8:07 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 8:07 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 11/25/2019 8:07 am

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

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

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

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

		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.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	596,700	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 8:07 am

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2018	12/31/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/25/2019 8:07 am

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part II Date/Time Prepared: 11/25/2019 8:07 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		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.		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.		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.		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.	JOHN	KUHN	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.	317-583-3236	JOHN.KUHN@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/25/2019 8:07 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 11/25/2019 8:07 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	128	46,720	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)		128	46,720	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	15	5,475	0.00	0	12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		153	55,845	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)		153				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: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 11/25/2019 8:07 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,020	256	12,743			1.00
2.00	HMO and other (see instructions)	1,630	2,621				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)	4,020	256	12,743			7.00
8.00	INTENSIVE CARE UNIT	569	158	1,249			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	NEONATAL INTENSIVE CARE UNIT	0	308	2,129			12.00
13.00	NURSERY		96	3,080			13.00
14.00	Total (see instructions)	4,589	818	19,201	0.00	457.59	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	457.59	27.00
28.00	Observation Bed Days		0	2,172			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			831			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	891			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 11/25/2019 8:07 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,225	70	6,722	1.00
2.00	HMO and other (see instructions)			395	646		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	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,225	70	6,722	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part II Date/Time Prepared: 11/25/2019 8:07 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	35,084,105	14,266	35,098,371	952,011.64	36.87	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		154,881	0	154,881	852.96	181.58	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		2,069,717	0	2,069,717	16,180.96	127.91	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		424,774	0	424,774	11,941.68	35.57	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,228,259	0	1,228,259	39,953.65	30.74	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		861,422	0	861,422	3,114.97	276.54	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		1,682,357	0	1,682,357	37,130.65	45.31	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		8,299,137	0	8,299,137	174,571.22	47.54	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,770,349	0	7,770,349			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		306,872	0	306,872			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		38,072	0	38,072			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		508,759	0	508,759			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		2,483,765	0	2,483,765			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	16,466	14,266	30,732	1,259.20	24.41	26.00
27.00	Administrative & General	5.00	1,660,005	0	1,660,005	49,638.06	33.44	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part II Date/Time Prepared: 11/25/2019 8:07 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		7,023,467	0	7,023,467	116,612.11	60.23	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	232,113	0	232,113	10,653.01	21.79	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,511,291	0	1,511,291	62,679.04	24.11	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		761,179	0	761,179	29,806.61	25.54	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,547,419	0	1,547,419	35,841.22	43.17	38.00
39.00	Central Services and Supply	14.00	389,251	0	389,251	20,093.30	19.37	39.00
40.00	Pharmacy	15.00	1,771,869	0	1,771,869	38,124.88	46.48	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	63,163	0	63,163	2,023.12	31.22	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part III Date/Time Prepared: 11/25/2019 8:07 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		41,885,551	14,266	41,899,817	1,132,986.76	36.98	1.00
2.00	Excluded area salaries (see instructions)		1,228,259	0	1,228,259	39,953.65	30.74	2.00
3.00	Subtotal salaries (line 1 minus line 2)		40,657,292	14,266	40,671,558	1,093,033.11	37.21	3.00
4.00	Subtotal other wages & related costs (see inst.)		10,842,916	0	10,842,916	214,816.84	50.48	4.00
5.00	Subtotal wage-related costs (see inst.)		10,292,186	0	10,292,186	0.00	25.31	5.00
6.00	Total (sum of lines 3 thru 5)		61,792,394	14,266	61,806,660	1,307,849.95	47.26	6.00
7.00	Total overhead cost (see instructions)		14,976,223	14,266	14,990,489	366,730.55	40.88	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 11/25/2019 8:07 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,254,400	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	348,469	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	273,905	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,676,339	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,291,213	9.00
10.00	Dental, Hearing and Vision Plan	66,400	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	15,740	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-3,333	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	202,587	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	60,073	14.00
15.00	'Workers' Compensation Insurance	7,335	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,396,406	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	10,618	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	6,094	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	17,807	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,624,053	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part V Date/Time Prepared: 11/25/2019 8:07 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	861,422	8,624,053	1.00
2.00	Hospital	861,422	8,624,053	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-10 | Date/Time Prepared: 11/25/2019 8:07 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.179698	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,503,373	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	70,119,742	6.00
7.00	Medicaid cost (line 1 times line 6)	12,600,377	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	8,097,004	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	8,097,004	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	8,885,363	3,299,648	12,185,011	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,596,682	3,299,648	4,896,330	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,596,682	3,299,648	4,896,330	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,182,308	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	84,475	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	129,961	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,052,347	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	593,987	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	5,490,317	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	13,587,321	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A | Date/Time Prepared: 11/25/2019 8:07 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		7,425,294	7,425,294	0	7,425,294	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,766,986	3,766,986	0	3,766,986	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,466	6,534,589	6,551,055	0	6,551,055	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,660,005	33,911,980	35,571,985	0	35,571,985	5.00
7.00	00700	OPERATION OF PLANT	232,113	4,319,178	4,551,291	0	4,551,291	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	560,424	560,424	0	560,424	8.00
9.00	00900	HOUSEKEEPING	0	1,952,769	1,952,769	0	1,952,769	9.00
10.00	01000	DIETARY	0	1,938,435	1,938,435	-906,327	1,032,108	10.00
11.00	01100	CAFETERIA	0	8,429	8,429	906,327	914,756	11.00
13.00	01300	NURSING ADMINISTRATION	1,547,419	348,297	1,895,716	0	1,895,716	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	389,251	32,946	422,197	0	422,197	14.00
15.00	01500	PHARMACY	1,771,869	232,613	2,004,482	0	2,004,482	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	63,163	56,867	120,030	0	120,030	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,529,799	2,411,522	11,941,321	-1,041,715	10,899,606	30.00
31.00	03100	INTENSIVE CARE UNIT	1,133,726	902,817	2,036,543	0	2,036,543	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,545,874	-204,766	1,341,108	0	1,341,108	35.00
43.00	04300	NURSERY	0	0	0	1,041,715	1,041,715	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,935,031	5,338,439	9,273,470	0	9,273,470	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,900,013	1,692,208	3,592,221	0	3,592,221	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,640,218	987,231	2,627,449	0	2,627,449	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	462,393	45,561	507,954	0	507,954	54.02
57.00	05700	CT SCAN	502,475	213,591	716,066	0	716,066	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	255,158	217,312	472,470	0	472,470	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	342	3,000,377	3,000,719	0	3,000,719	60.00
65.00	06500	RESPIRATORY THERAPY	754,666	199,045	953,711	0	953,711	65.00
66.00	06600	PHYSICAL THERAPY	516,049	61,499	577,548	0	577,548	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,083	1,457	6,540	0	6,540	68.00
69.00	06900	ELECTROCARDIOLOGY	102,070	16,840	118,910	0	118,910	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,557	2,659	13,216	0	13,216	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,112,719	5,112,719	0	5,112,719	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,539,452	6,539,452	0	6,539,452	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,556,064	3,556,064	0	3,556,064	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,689,415	7,054,755	9,744,170	0	9,744,170	75.00
76.00	03330	ENDOSCOPY	1,738,914	1,678,503	3,417,417	0	3,417,417	76.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,453,777	831,711	2,285,488	0	2,285,488	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,855,846	100,747,803	134,603,649	0	134,603,649	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	111,205	395,196	506,401	0	506,401	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	402,563	73,019	475,582	0	475,582	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	543,242	38,774	582,016	0	582,016	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	171,249	63,708	234,957	0	234,957	194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	35,084,105	101,318,500	136,402,605	0	136,402,605	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A | Date/Time Prepared: 11/25/2019 8:07 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-784,570	6,640,724	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	30,056	3,797,042	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,565	6,546,490	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-11,232,206	24,339,779	5.00
7.00	00700	OPERATION OF PLANT	-5,171	4,546,120	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	560,424	8.00
9.00	00900	HOUSEKEEPING	0	1,952,769	9.00
10.00	01000	DIETARY	-2,434	1,029,674	10.00
11.00	01100	CAFETERIA	-409,599	505,157	11.00
13.00	01300	NURSING ADMINISTRATION	-24,464	1,871,252	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	422,197	14.00
15.00	01500	PHARMACY	-5,135	1,999,347	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	-1,916	118,114	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,159,812	8,739,794	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,036,543	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	4,627	1,345,735	35.00
43.00	04300	NURSERY	0	1,041,715	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-354	9,273,116	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-886,193	2,706,028	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-30,867	2,596,582	54.00
54.01	03480	ONCOLOGY	0	0	54.01
54.02	05402	ULTRASOUND	0	507,954	54.02
57.00	05700	CT SCAN	-21,484	694,582	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-3,088	469,382	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	3,000,719	60.00
65.00	06500	RESPIRATORY THERAPY	-25	953,686	65.00
66.00	06600	PHYSICAL THERAPY	0	577,548	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,540	68.00
69.00	06900	ELECTROCARDIOLOGY	0	118,910	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,216	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,112,719	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,539,452	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,556,064	73.00
75.00	07500	ASC (NON-DISTINCT PART)	-790,406	8,953,764	75.00
76.00	03330	ENDOSCOPY	-67,484	3,349,933	76.00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-19,655	2,265,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-16,414,745	118,188,904	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	506,401	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	475,582	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	194.00
194.01	07951	MARKETING	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	194.02
194.04	07954	SCHOOL NURSE	0	582,016	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	234,957	194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	-16,414,745	119,987,860	200.00

RECLASSIFICATIONS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-6 | Date/Time Prepared: 11/25/2019 8:07 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - NURSERY				
1.00	NURSERY	43.00	872,892	168,823	1.00
	0		872,892	168,823	
	B - ACCRUED PTO				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	14,266	0	1.00
	0		14,266	0	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	0	906,327	1.00
	0		0	906,327	
500.00	Grand Total: Increases		887,158	1,075,150	500.00

RECLASSIFICATIONS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-6 Date/Time Prepared: 11/25/2019 8:07 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	872,892	168,823	0		1.00
	0		872,892	168,823			
	B - ACCRUED PTO						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	14,266	0		1.00
	0		0	14,266			
	C - CAFETERIA						
1.00	DIETARY	10.00	0	906,327	0		1.00
	0		0	906,327			
500.00	Grand Total: Decreases		872,892	1,089,416			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-7 Part I Date/Time Prepared: 11/25/2019 8:07 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	15,676,014	0	0	0	0	1.00
2.00	Land Improvements	2,487,972	76,828	0	76,828	0	2.00
3.00	Buildings and Fixtures	82,496,314	1,211,663	0	1,211,663	29,428	3.00
4.00	Building Improvements	2,795,304	492,731	0	492,731	0	4.00
5.00	Fixed Equipment	16,756,962	840,350	0	840,350	1,469,830	5.00
6.00	Movable Equipment	48,920,653	1,664,631	0	1,664,631	3,876,187	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	169,133,219	4,286,203	0	4,286,203	5,375,445	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	169,133,219	4,286,203	0	4,286,203	5,375,445	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	15,676,014	0	1.00
2.00	Land Improvements	2,564,800	0	2.00
3.00	Buildings and Fixtures	83,678,549	0	3.00
4.00	Building Improvements	3,288,035	0	4.00
5.00	Fixed Equipment	16,127,482	0	5.00
6.00	Movable Equipment	46,709,097	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	168,043,977	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	168,043,977	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-7 Part II | Date/Time Prepared: 11/25/2019 8:07 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,436,003	3,755,613	0	0	233,678	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,862,062	903,591	0	0	1,333	2.00
3.00	Total (sum of lines 1-2)	6,298,065	4,659,204	0	0	235,011	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	7,425,294	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,766,986	2.00
3.00	Total (sum of lines 1-2)	0	11,192,280	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-7 Part III Date/Time Prepared: 11/25/2019 8:07 am

	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	121,334,879	0	121,334,879	0.722042	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	46,709,097	0	46,709,097	0.277958	0	2.00
3.00	Total (sum of lines 1-2)	168,043,976	0	168,043,976	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	3,436,003	3,755,613	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,862,062	903,591	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,298,065	4,659,204	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	5,340	0	233,678	-789,910	6,640,724	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	1,333	30,056	3,797,042	2.00
3.00	Total (sum of lines 1-2)	5,340	0	235,011	-759,854	10,437,766	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8 | Date/Time Prepared: 11/25/2019 8:07 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-746,363	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	-40,201	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-4,900	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,090,864			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,568,312			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-407,479	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	0	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-2,120	CAFETERIA	11.00	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	DONATIONS MADE	B	240	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8 | Date/Time Prepared: 11/25/2019 8:07 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	BILLING ARRANGEMENTS	B	-1,493,933	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	UNRLEATED BUS INCOME TAX UBI	B	240	ADMINISTRATIVE & GENERAL	5.00	9	33.02
33.03	MEALS ON WHEELS	B	-1,929	DIETARY	10.00	0	33.03
34.00	ADMINISTRATIVE FEES	B	-31	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	CONSOLIDATING ENTRY	B	-2,771,087	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	SEMINARS TUITION REVENUE	B	-3,865	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
37.00	OTHER MISC REVENUE - EMPLOYEE EDUCAT	B	-700	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.00
38.00	OTHER MISC REVENUE - ADMIN	B	-16,523	ADMINISTRATIVE & GENERAL	5.00	0	38.00
38.01	OTHER MISC REVENUE - ROUTINE	B	-4,615	ADULTS & PEDIATRICS	30.00	0	38.01
39.00	OTHER MISC REVENUE - RADIOLOGY	B	-2,028	RADIOLOGY-DIAGNOSTIC	54.00	0	39.00
40.00	OTHER MISC REVENUE - CT SCAN	B	150	CT SCAN	57.00	0	40.00
41.00	OTHER MISC REVENUE - ASC	B	-776,763	ASC (NON-DISTINCT PART)	75.00	0	41.00
42.00	OTHER MISC REVENUE - ENDO	B	-65,195	ENDOSCOPY	76.00	0	42.00
42.01	LATE PENALTY FEES - MAINT	B	-271	OPERATION OF PLANT	7.00	0	42.01
43.00	LATE PENALTY FEES - NEONATOLOGY	B	-4	NEONATAL INTENSIVE CARE UNIT	35.00	10	43.00
44.00	VENDING MACHINES - DIETARY	B	-505	DIETARY	10.00	0	44.00
44.01	UNCLAIMED PROPERTY EXEMPTIONS	B	-4,980	ADMINISTRATIVE & GENERAL	5.00	0	44.01
45.00	RENTAL OF HOSPITAL SPACE	B	-742,179	CAP REL COSTS-BLDG & FIXT	1.00	14	45.00
46.00	CONTRACT SERVICES REVENUE	B	-7,606	ADULTS & PEDIATRICS	30.00	14	46.00
47.00	IFUE OPERATING COMFORT IMAGING	B	-47,416	CAP REL COSTS-BLDG & FIXT	1.00	14	47.00
49.00	LOSS ON SALE DISPOSAL PPE	A	30,056	CAP REL COSTS-MVBLE EQUIP	2.00	14	49.00
49.01	ENTERTAINMENT - A&G	A	-1,698	ADMINISTRATIVE & GENERAL	5.00	0	49.01
49.02	ENTERTAINMENT - NURS ADMIN	A	-380	NURSING ADMINISTRATION	13.00	0	49.02
49.03	ENTERTAINMENT - ROUTINE	A	-463	ADULTS & PEDIATRICS	30.00	0	49.03
49.04	ENTERTAIMENT - L&D	A	-234	DELIVERY ROOM & LABOR ROOM	52.00	0	49.04
49.05	ENTERTAINMENT - RT	A	-25	RESPIRATORY THERAPY	65.00	0	49.05
49.06	ENTERTAINMENT - EMERGENCY	A	-109	EMERGENCY	91.00	0	49.06
49.07	ENTERTAINMENT - RADIOLOGY	A	-205	RADIOLOGY-DIAGNOSTIC	54.00	0	49.07
49.08	ADVERTISING - ENDO	A	-2,289	ENDOSCOPY	76.00	0	49.08
49.09	ADVERTISING - ASC	A	-13,643	ASC (NON-DISTINCT PART)	75.00	0	49.09
49.10	MARKETING - ADMIN	A	-6,633	ADMINISTRATIVE & GENERAL	5.00	0	49.10
49.11	MARKETING - NURS ADMIN	A	-869	NURSING ADMINISTRATION	13.00	0	49.11
49.12	MARKETING - ROUTINE	A	-10,294	ADULTS & PEDIATRICS	30.00	0	49.12
49.13	MARKETING - OR	A	-354	OPERATING ROOM	50.00	0	49.13
49.14	MARKETING - L&D	A	-200	DELIVERY ROOM & LABOR ROOM	52.00	0	49.14
49.15	CHARITABLE EXP - A&G	A	-1,300	ADMINISTRATIVE & GENERAL	5.00	0	49.15
49.16	CHARITABLE EXP - CASE MGMT	A	-23,215	NURSING ADMINISTRATION	13.00	0	49.16
49.17	CHARITABLE EXP - PHARMACY	A	-5,135	PHARMACY	15.00	0	49.17
49.18	CHARITABLE EXP - SOC SVC	A	-1,916	SOCIAL SERVICE	17.00	0	49.18
49.19	LATE PENALTY FEES	A	-3,155	ADMINISTRATIVE & GENERAL	5.00	0	49.19
49.20	SCHOLARSHIP EXPENSE	A	-2,000	ADMINISTRATIVE & GENERAL	5.00	0	49.20
49.21	TELEPHONE OFFSET - DEPR	A	-315	CAP REL COSTS-BLDG & FIXT	1.00	14	49.21
49.22	LOBBYING	A	-1,669	ADMINISTRATIVE & GENERAL	5.00	0	49.22
49.23	PROVIDER ASSESSMENT OFFSET	A	-7,706,085	ADMINISTRATIVE & GENERAL	5.00	0	49.23
49.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.24
49.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.25
49.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.26
49.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.27
49.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.28
49.29	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.29
49.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.30
49.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.31
49.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.32
49.33	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.33
49.34	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.34

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8 Date/Time Prepared: 11/25/2019 8:07 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,414,745				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: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet A-8-1 Date/Time Prepared: 11/25/2019 8:07 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	5,325,806	5,325,806	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	H.O. COSTS - CAPITAL	2,474,070	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	H.O. COSTS - INTEREST	34,861	0	3.00
3.02	5.00	ADMINISTRATIVE & GENERAL	H.O. COSTS - OTHER	23,004,747	24,697,069	3.02
3.03	0.00			0	0	3.03
3.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACK	106,195	106,195	3.04
3.05	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK	206,372	206,372	3.05
3.06	13.00	NURSING ADMINISTRATION	SVH CHARGEBACK	-4,805	-4,805	3.06
3.07	15.00	PHARMACY	SVH CHARGEBACK	-105,319	-105,319	3.07
3.08	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACK	1,318	1,318	3.08
3.09	31.00	INTENSIVE CARE UNIT	SVH CHARGEBACK	510,600	510,600	3.09
3.10	35.00	NEONATAL INTENSIVE CARE UNIT	SVH CHARGEBACK	-5,342	-5,342	3.10
3.11	52.00	DELIVERY ROOM & LABOR ROOM	SVH CHARGEBACK	334,529	334,529	3.11
3.12	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	77,758	77,758	3.12
3.13	66.00	PHYSICAL THERAPY	SVH CHARGEBACK	39,794	39,794	3.13
4.00	70.00	ELECTROENCEPHALOGRAPHY	SVH CHARGEBACK	6,335	6,335	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
4.14	0.00			0	0	4.14
4.15	0.00		0	0	0	4.15
4.16	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	751,703	0	4.16
4.17	0.00		0	0	0	4.17
4.18	0.00		0	0	0	4.18
4.20	0.00			0	0	4.20
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			32,758,622	31,190,310	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8-1 | Date/Time Prepared: 11/25/2019 8:07 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	0	0	1.00
2.00	2,474,070	0	2.00
3.00	34,861	0	3.00
3.02	-1,692,322	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
3.09	0	0	3.09
3.10	0	0	3.10
3.11	0	0	3.11
3.12	0	0	3.12
3.13	0	0	3.13
4.00	0	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
4.14	0	0	4.14
4.15	0	0	4.15
4.16	751,703	11	4.16
4.17	0	0	4.17
4.18	0	0	4.18
4.20	0	0	4.20
5.00	1,568,312		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.

	Type of Business	
6.00	HOME OFFICE	6.00
7.00	HOME OFFICE	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8-2 | Date/Time Prepared: 11/25/2019 8:07 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	2,467,255	2,136,834	330,421	211,500	8,923	1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	-4,631	-4,631	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1,052,422	0	1,052,422	246,400	23,381	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	885,759	885,759	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	64,059	16,640	47,419	271,900	271	5.00
6.00	57.00	CT SCAN	21,634	21,634	0	0	0	6.00
7.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	3,088	3,088	0	0	0	7.00
8.00	91.00	EMERGENCY	144,107	0	144,107	211,500	1,225	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,633,693	3,059,324	1,574,369		33,800	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	907,315	45,366	0	0	0	1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	2,769,749	138,487	0	0	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	35,425	1,771	0	0	0	5.00
6.00	57.00	CT SCAN	0	0	0	0	0	6.00
7.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	124,561	6,228	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,837,050	191,852	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	907,315	0	2,136,834	1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	-4,631	2.00
3.00	50.00	OPERATING ROOM	0	2,769,749	0	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	885,759	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	35,425	11,994	28,634	5.00
6.00	57.00	CT SCAN	0	0	0	21,634	6.00
7.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,088	7.00
8.00	91.00	EMERGENCY	0	124,561	19,546	19,546	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	3,837,050	31,540	3,090,864	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I Date/Time Prepared: 11/25/2019 8:07 am

		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	6,640,724	6,640,724				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,797,042		3,797,042			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,546,490	87,390	0	6,633,880		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,339,779	421,921	462,352	314,030	25,538,082	5.00
7.00	00700	OPERATION OF PLANT	4,546,120	775,636	49,360	43,910	5,415,026	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	560,424	34,215	0	0	594,639	8.00
9.00	00900	HOUSEKEEPING	1,952,769	119,215	3,189	0	2,075,173	9.00
10.00	01000	DIETARY	1,029,674	145,859	1,833	0	1,177,366	10.00
11.00	01100	CAFETERIA	505,157	170,180	5,418	0	680,755	11.00
13.00	01300	NURSING ADMINISTRATION	1,871,252	3,060	78,716	292,731	2,245,759	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	422,197	147,936	46,027	73,636	689,796	14.00
15.00	01500	PHARMACY	1,999,347	116,424	0	335,192	2,450,963	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,767	0	0	6,767	16.00
17.00	01700	SOCIAL SERVICE	118,114	16,058	0	11,949	146,121	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,739,794	1,507,118	269,493	1,637,657	12,154,062	30.00
31.00	03100	INTENSIVE CARE UNIT	2,036,543	154,301	97,980	214,471	2,503,295	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,345,735	153,586	33,095	292,439	1,824,855	35.00
43.00	04300	NURSERY	1,041,715	271,752	15,020	165,128	1,493,615	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,273,116	592,101	1,313,727	744,406	11,923,350	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,706,028	314,520	71,970	359,433	3,451,951	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,596,582	306,704	258,111	310,287	3,471,684	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	507,954	19,274	117,011	87,473	731,712	54.02
57.00	05700	CT SCAN	694,582	85,983	180,825	95,055	1,056,445	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	469,382	177,952	184,688	48,269	880,291	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,000,719	107,803	0	65	3,108,587	60.00
65.00	06500	RESPIRATORY THERAPY	953,686	54,225	58,122	142,763	1,208,796	65.00
66.00	06600	PHYSICAL THERAPY	577,548	45,136	0	97,623	720,307	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,540	514	0	962	8,016	68.00
69.00	06900	ELECTROCARDIOLOGY	118,910	4,444	15,058	19,309	157,721	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,216	491	0	1,997	15,704	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,112,719	0	0	0	5,112,719	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,539,452	0	0	0	6,539,452	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,556,064	0	0	0	3,556,064	73.00
75.00	07500	ASC (NON-DISTINCT PART)	8,953,764	283,120	201,317	508,767	9,946,968	75.00
76.00	03330	ENDOSCOPY	3,349,933	117,496	234,998	328,957	4,031,384	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,265,833	304,068	70,306	275,017	2,915,224	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118,188,904	6,545,249	3,768,616	6,401,526	117,832,649	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	506,401	36,939	0	21,037	564,377	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	475,582	0	0	76,154	551,736	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	582,016	19,765	0	102,767	704,548	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	234,957	38,771	28,426	32,396	334,550	194.06
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)	119,987,860	6,640,724	3,797,042	6,633,880	119,987,860	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I Date/Time Prepared: 11/25/2019 8:07 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,538,082					5.00
7.00	00700	OPERATION OF PLANT	1,464,158	6,879,184				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	160,783	43,947	799,369			8.00
9.00	00900	HOUSEKEEPING	561,102	153,125	0	2,789,400		9.00
10.00	01000	DIETARY	318,346	187,347	0	78,207	1,761,266	10.00
11.00	01100	CAFETERIA	184,068	218,586	0	91,247	0	11.00
13.00	01300	NURSING ADMINISTRATION	607,226	3,930	0	1,641	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	186,513	190,015	20,427	79,320	0	14.00
15.00	01500	PHARMACY	662,711	149,539	0	62,424	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,830	8,692	0	3,628	0	16.00
17.00	01700	SOCIAL SERVICE	39,509	20,625	0	8,610	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,286,307	1,935,807	248,688	808,090	1,564,254	30.00
31.00	03100	INTENSIVE CARE UNIT	676,861	198,191	25,977	82,733	98,055	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	493,419	197,273	0	82,350	0	35.00
43.00	04300	NURSERY	403,856	349,050	68,776	145,708	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,223,931	760,519	162,596	317,473	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	933,366	403,983	18,881	168,640	98,957	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	938,702	393,943	49,805	164,449	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	197,846	24,756	7,124	10,334	0	54.02
57.00	05700	CT SCAN	285,650	110,441	10,041	46,103	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	238,020	228,569	17,283	95,414	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	840,525	138,467	0	57,802	0	60.00
65.00	06500	RESPIRATORY THERAPY	326,844	69,649	410	29,075	0	65.00
66.00	06600	PHYSICAL THERAPY	194,762	57,974	1,048	24,201	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,167	660	12	275	0	68.00
69.00	06900	ELECTROCARDIOLOGY	42,646	5,708	51	2,383	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,246	631	5	263	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,382,418	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,768,189	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	961,517	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,689,541	363,651	32,483	151,803	0	75.00
76.00	03330	ENDOSCOPY	1,090,038	150,916	47,091	62,999	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	788,242	390,558	85,021	163,036	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,955,339	6,756,552	795,719	2,738,208	1,761,266	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	152,601	47,446	0	19,806	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	149,183	0	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	190,501	25,387	0	10,598	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	90,458	49,799	3,650	20,788	0	194.06
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)	25,538,082	6,879,184	799,369	2,789,400	1,761,266	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I | Date/Time Prepared: 11/25/2019 8:07 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,174,656					11.00
13.00	01300	NURSING ADMINISTRATION	48,469	2,907,025				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,173	0	1,193,244			14.00
15.00	01500	PHARMACY	51,558	0	4,112	3,381,307		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	20,917	16.00
17.00	01700	SOCIAL SERVICE	2,736	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	278,624	1,036,996	24,747	0	1,885	30.00
31.00	03100	INTENSIVE CARE UNIT	34,290	127,622	9,004	0	345	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	54,317	202,159	4,233	0	586	35.00
43.00	04300	NURSERY	33,627	125,156	4,654	0	314	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	150,792	561,223	220,624	0	6,835	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	76,042	283,017	12,436	0	1,334	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,335	0	32,200	0	1,104	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	16,642	0	235	0	125	54.02
57.00	05700	CT SCAN	16,991	0	6,675	0	343	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,666	0	4,417	0	127	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	12	0	0	0	1,524	60.00
65.00	06500	RESPIRATORY THERAPY	29,396	0	7,192	0	186	65.00
66.00	06600	PHYSICAL THERAPY	17,833	0	551	0	117	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	189	0	0	0	4	68.00
69.00	06900	ELECTROCARDIOLOGY	2,879	0	573	0	217	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	492	0	0	0	50	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	278,863	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	366,753	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,378,788	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	112,607	0	166,917	0	2,316	75.00
76.00	03330	ENDOSCOPY	68,653	255,516	36,638	0	1,817	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	48,855	181,830	11,856	0	1,688	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,150,178	2,773,519	1,192,680	3,378,788	20,917	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,334	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,825	0	29	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	109,986	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	6,319	23,520	535	2,519	0	194.06
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)	1,174,656	2,907,025	1,193,244	3,381,307	20,917	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I Date/Time Prepared: 11/25/2019 8:07 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	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
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	217,601					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,841	21,388,301	0	21,388,301		30.00
31.00	03100	INTENSIVE CARE UNIT	22,330	3,778,703	0	3,778,703		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	36,251	2,895,443	0	2,895,443		35.00
43.00	04300	NURSERY	0	2,624,756	0	2,624,756		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,275	17,331,618	0	17,331,618		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,529	5,476,136	0	5,476,136		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,121,222	0	5,121,222		54.00
54.01	03480	ONCOLOGY	0	0	0	0		54.01
54.02	05402	ULTRASOUND	0	988,774	0	988,774		54.02
57.00	05700	CT SCAN	0	1,532,689	0	1,532,689		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,472,787	0	1,472,787		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	4,146,917	0	4,146,917		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,671,548	0	1,671,548		65.00
66.00	06600	PHYSICAL THERAPY	0	1,016,793	0	1,016,793		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	11,323	0	11,323		68.00
69.00	06900	ELECTROCARDIOLOGY	0	212,178	0	212,178		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	21,391	0	21,391		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,774,000	0	6,774,000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,674,394	0	8,674,394		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,896,369	0	7,896,369		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	13,466,286	0	13,466,286		75.00
76.00	03330	ENDOSCOPY	11,400	5,756,452	0	5,756,452		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	55,559	4,641,869	0	4,641,869		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	206,185	116,899,949	0	116,899,949		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	791,564	0	791,564		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,416	723,189	0	723,189		192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
194.02	07952	JOINT VENTURES	0	0	0	0		194.02
194.04	07954	SCHOOL NURSE	0	1,041,020	0	1,041,020		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	532,138	0	532,138		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	217,601	119,987,860	0	119,987,860		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II | Date/Time Prepared: 11/25/2019 8:07 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			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	87,390	0	87,390	87,390	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,474,070	421,921	462,352	3,358,343	4,137	5.00
7.00	00700	OPERATION OF PLANT	0	775,636	49,360	824,996	578	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,215	0	34,215	0	8.00
9.00	00900	HOUSEKEEPING	0	119,215	3,189	122,404	0	9.00
10.00	01000	DIETARY	0	145,859	1,833	147,692	0	10.00
11.00	01100	CAFETERIA	0	170,180	5,418	175,598	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,060	78,716	81,776	3,856	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	147,936	46,027	193,963	970	14.00
15.00	01500	PHARMACY	0	116,424	0	116,424	4,415	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,767	0	6,767	0	16.00
17.00	01700	SOCIAL SERVICE	0	16,058	0	16,058	157	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,507,118	269,493	1,776,611	21,577	30.00
31.00	03100	INTENSIVE CARE UNIT	0	154,301	97,980	252,281	2,825	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	153,586	33,095	186,681	3,852	35.00
43.00	04300	NURSERY	0	271,752	15,020	286,772	2,175	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	592,101	1,313,727	1,905,828	9,806	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	314,520	71,970	386,490	4,735	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	306,704	258,111	564,815	4,087	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	19,274	117,011	136,285	1,152	54.02
57.00	05700	CT SCAN	0	85,983	180,825	266,808	1,252	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	177,952	184,688	362,640	636	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	107,803	0	107,803	1	60.00
65.00	06500	RESPIRATORY THERAPY	0	54,225	58,122	112,347	1,881	65.00
66.00	06600	PHYSICAL THERAPY	0	45,136	0	45,136	1,286	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	514	0	514	13	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,444	15,058	19,502	254	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	491	0	491	26	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
75.00	07500	ASC (NON-DISTINCT PART)	0	283,120	201,317	484,437	6,702	75.00
76.00	03330	ENDOSCOPY	0	117,496	234,998	352,494	4,333	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	304,068	70,306	374,374	3,623	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,474,070	6,545,249	3,768,616	12,787,935	84,329	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	36,939	0	36,939	277	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,003	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	19,765	0	19,765	1,354	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	38,771	28,426	67,197	427	194.06
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)	2,474,070	6,640,724	3,797,042	12,911,836	87,390	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II | Date/Time Prepared: 11/25/2019 8:07 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,362,480					5.00
7.00	00700	OPERATION OF PLANT	192,780	1,018,354				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,170	6,506	61,891			8.00
9.00	00900	HOUSEKEEPING	73,878	22,668	0	218,950		9.00
10.00	01000	DIETARY	41,915	27,734	0	6,139	223,480	10.00
11.00	01100	CAFETERIA	24,236	32,358	0	7,162	0	11.00
13.00	01300	NURSING ADMINISTRATION	79,951	582	0	129	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24,557	28,129	1,582	6,226	0	14.00
15.00	01500	PHARMACY	87,257	22,137	0	4,900	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241	1,287	0	285	0	16.00
17.00	01700	SOCIAL SERVICE	5,202	3,053	0	676	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	432,673	286,564	19,254	63,428	198,482	30.00
31.00	03100	INTENSIVE CARE UNIT	89,120	29,339	2,011	6,494	12,442	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	64,967	29,203	0	6,464	0	35.00
43.00	04300	NURSERY	53,174	51,671	5,325	11,437	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	424,483	112,583	12,589	24,920	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	122,893	59,803	1,462	13,237	12,556	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	123,595	58,317	3,856	12,908	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	26,050	3,665	552	811	0	54.02
57.00	05700	CT SCAN	37,610	16,349	777	3,619	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	31,339	33,836	1,338	7,489	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	110,669	20,498	0	4,537	0	60.00
65.00	06500	RESPIRATORY THERAPY	43,034	10,310	32	2,282	0	65.00
66.00	06600	PHYSICAL THERAPY	25,644	8,582	81	1,900	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	285	98	1	22	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,615	845	4	187	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	559	93	0	21	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	182,018	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	232,811	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	126,599	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	354,122	53,833	2,515	11,916	0	75.00
76.00	03330	ENDOSCOPY	143,521	22,341	3,646	4,945	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	103,785	57,816	6,583	12,797	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,285,753	1,000,200	61,608	214,931	223,480	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,092	7,024	0	1,555	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,642	0	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	25,083	3,758	0	832	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	11,910	7,372	283	1,632	0	194.06
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)	3,362,480	1,018,354	61,891	218,950	223,480	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II Date/Time Prepared: 11/25/2019 8:07 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	239,354					11.00
13.00	01300	NURSING ADMINISTRATION	9,876	176,170				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,537	0	260,964			14.00
15.00	01500	PHARMACY	10,506	0	899	246,538		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	8,580	16.00
17.00	01700	SOCIAL SERVICE	557	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	56,774	62,844	5,412	0	794	30.00
31.00	03100	INTENSIVE CARE UNIT	6,987	7,734	1,969	0	145	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	11,068	12,251	926	0	247	35.00
43.00	04300	NURSERY	6,852	7,585	1,018	0	132	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,726	34,011	48,250	0	2,651	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,495	17,151	2,720	0	562	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,128	0	7,042	0	465	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	3,391	0	51	0	53	54.02
57.00	05700	CT SCAN	3,462	0	1,460	0	144	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,766	0	966	0	53	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2	0	0	0	642	60.00
65.00	06500	RESPIRATORY THERAPY	5,990	0	1,573	0	78	65.00
66.00	06600	PHYSICAL THERAPY	3,634	0	120	0	49	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	39	0	0	0	2	68.00
69.00	06900	ELECTROCARDIOLOGY	587	0	125	0	91	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	100	0	0	0	21	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	60,987	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	80,213	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	246,354	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	22,945	0	36,504	0	975	75.00
76.00	03330	ENDOSCOPY	13,989	15,485	8,013	0	765	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,955	11,019	2,593	0	711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	234,366	168,080	260,841	246,354	8,580	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,494	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,206	0	6	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	6,665	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,288	1,425	117	184	0	194.06
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)	239,354	176,170	260,964	246,538	8,580	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II Date/Time Prepared: 11/25/2019 8:07 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	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
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	25,703					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,769	2,930,182	0	2,930,182		30.00
31.00	03100	INTENSIVE CARE UNIT	2,638	413,985	0	413,985		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	4,282	319,941	0	319,941		35.00
43.00	04300	NURSERY	0	426,141	0	426,141		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	505	2,606,352	0	2,606,352		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,252	640,356	0	640,356		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	789,213	0	789,213		54.00
54.01	03480	ONCOLOGY	0	0	0	0		54.01
54.02	05402	ULTRASOUND	0	172,010	0	172,010		54.02
57.00	05700	CT SCAN	0	331,481	0	331,481		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	440,063	0	440,063		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	244,152	0	244,152		60.00
65.00	06500	RESPIRATORY THERAPY	0	177,527	0	177,527		65.00
66.00	06600	PHYSICAL THERAPY	0	86,432	0	86,432		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	974	0	974		68.00
69.00	06900	ELECTROCARDIOLOGY	0	27,210	0	27,210		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,311	0	1,311		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	243,005	0	243,005		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	313,024	0	313,024		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	372,953	0	372,953		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	973,949	0	973,949		75.00
76.00	03330	ENDOSCOPY	1,347	570,879	0	570,879		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,562	589,818	0	589,818		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,355	12,670,958	0	12,670,958		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	67,381	0	67,381		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,348	24,205	0	24,205		192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
194.02	07952	JOINT VENTURES	0	0	0	0		194.02
194.04	07954	SCHOOL NURSE	0	57,457	0	57,457		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	91,835	0	91,835		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	25,703	12,911,836	0	12,911,836		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B-1 | Date/Time Prepared: 11/25/2019 8:07 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	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	297,346					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,818,824				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,913	0	35,067,639			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,892	465,004	1,660,005	-25,538,082	94,449,778	5.00
7.00	00700	OPERATION OF PLANT	34,730	49,643	232,113	0	5,415,026	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,532	0	0	0	594,639	8.00
9.00	00900	HOUSEKEEPING	5,338	3,207	0	0	2,075,173	9.00
10.00	01000	DIETARY	6,531	1,844	0	0	1,177,366	10.00
11.00	01100	CAFETERIA	7,620	5,449	0	0	680,755	11.00
13.00	01300	NURSING ADMINISTRATION	137	79,168	1,547,419	0	2,245,759	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,624	46,291	389,251	0	689,796	14.00
15.00	01500	PHARMACY	5,213	0	1,771,869	0	2,450,963	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303	0	0	0	6,767	16.00
17.00	01700	SOCIAL SERVICE	719	0	63,163	0	146,121	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,483	271,039	8,656,907	0	12,154,062	30.00
31.00	03100	INTENSIVE CARE UNIT	6,909	98,542	1,133,726	0	2,503,295	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,877	33,285	1,545,874	0	1,824,855	35.00
43.00	04300	NURSERY	12,168	15,106	872,892	0	1,493,615	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,512	1,321,264	3,935,031	0	11,923,350	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,083	72,383	1,900,013	0	3,451,951	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,733	259,592	1,640,218	0	3,471,684	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	863	117,682	462,393	0	731,712	54.02
57.00	05700	CT SCAN	3,850	181,862	502,475	0	1,056,445	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	185,748	255,158	0	880,291	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,827	0	342	0	3,108,587	60.00
65.00	06500	RESPIRATORY THERAPY	2,428	58,455	754,666	0	1,208,796	65.00
66.00	06600	PHYSICAL THERAPY	2,021	0	516,049	0	720,307	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	23	0	5,083	0	8,016	68.00
69.00	06900	ELECTROCARDIOLOGY	199	15,144	102,070	0	157,721	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22	0	10,557	0	15,704	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,112,719	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,539,452	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,556,064	73.00
75.00	07500	ASC (NON-DISTINCT PART)	12,677	202,472	2,689,415	0	9,946,968	75.00
76.00	03330	ENDOSCOPY	5,261	236,346	1,738,914	0	4,031,384	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,615	70,709	1,453,777	0	2,915,224	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	293,071	3,790,235	33,839,380	-25,538,082	92,294,567	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	0	111,205	0	564,377	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	402,563	0	551,736	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	885	0	543,242	0	704,548	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,736	28,589	171,249	0	334,550	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,640,724	3,797,042	6,633,880		25,538,082	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.333322	0.994296	0.189174		0.270388	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			87,390		3,362,480	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002492		0.035601	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: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B-1 | Date/Time Prepared: 11/25/2019 8:07 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	239,811					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,532	331,112				8.00
9.00	00900	HOUSEKEEPING	5,338	0	232,941			9.00
10.00	01000	DIETARY	6,531	0	6,531	44,905		10.00
11.00	01100	CAFETERIA	7,620	0	7,620	0	868,609	11.00
13.00	01300	NURSING ADMINISTRATION	137	0	137	0	35,841	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,624	8,461	6,624	0	20,093	14.00
15.00	01500	PHARMACY	5,213	0	5,213	0	38,125	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303	0	303	0	0	16.00
17.00	01700	SOCIAL SERVICE	719	0	719	0	2,023	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,483	103,011	67,483	39,882	206,031	30.00
31.00	03100	INTENSIVE CARE UNIT	6,909	10,760	6,909	2,500	25,356	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,877	0	6,877	0	40,165	35.00
43.00	04300	NURSERY	12,168	28,488	12,168	0	24,866	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,512	67,350	26,512	0	111,504	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,083	7,821	14,083	2,523	56,230	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,733	20,630	13,733	0	51,270	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	863	2,951	863	0	12,306	54.02
57.00	05700	CT SCAN	3,850	4,159	3,850	0	12,564	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	7,159	7,968	0	6,408	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,827	0	4,827	0	9	60.00
65.00	06500	RESPIRATORY THERAPY	2,428	170	2,428	0	21,737	65.00
66.00	06600	PHYSICAL THERAPY	2,021	434	2,021	0	13,187	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	23	5	23	0	140	68.00
69.00	06900	ELECTROCARDIOLOGY	199	21	199	0	2,129	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22	2	22	0	364	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
75.00	07500	ASC (NON-DISTINCT PART)	12,677	13,455	12,677	0	83,268	75.00
76.00	03330	ENDOSCOPY	5,261	19,506	5,261	0	50,766	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,615	35,217	13,615	0	36,126	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	235,536	329,600	228,666	44,905	850,508	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	0	1,654	0	5,423	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	8,005	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	885	0	885	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,736	1,512	1,736	0	4,673	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,879,184	799,369	2,789,400	1,761,266	1,174,656	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.685857	2.414195	11.974706	39.222047	1.352342	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,018,354	61,891	218,950	223,480	239,354	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.246486	0.186919	0.939938	4.976729	0.275560	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: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B-1 | Date/Time Prepared: 11/25/2019 8:07 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT REVENUE)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	577,569					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,276,613				14.00
15.00	01500	PHARMACY	0	73,318	3,558,715			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	547,269,883		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	13,896	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	206,031	441,262	0	49,603,402	3,119	30.00
31.00	03100	INTENSIVE CARE UNIT	25,356	160,551	0	9,087,219	1,426	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	40,165	75,476	0	15,428,069	2,315	35.00
43.00	04300	NURSERY	24,866	82,981	0	8,261,592	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	111,504	3,933,950	0	176,743,776	273	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,230	221,739	0	35,114,226	1,758	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	574,162	0	29,045,128	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	4,191	0	3,287,894	0	54.02
57.00	05700	CT SCAN	0	119,018	0	9,019,012	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	78,763	0	3,331,538	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	40,102,533	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	128,247	0	4,885,061	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,817	0	3,072,219	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	102,647	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,211	0	5,700,529	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,310,065	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,972,418	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,539,452	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,556,064	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	2,976,295	0	60,940,989	0	75.00
76.00	03330	ENDOSCOPY	50,766	653,301	0	47,809,400	728	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	36,126	211,402	0	44,424,584	3,548	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	551,044	21,266,554	3,556,064	547,269,883	13,167	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	516	0	0	729	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	21,852	0	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	4,673	9,543	2,651	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,907,025	1,193,244	3,381,307	20,917	217,601	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.033208	0.056082	0.950148	0.000038	15.659254	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	176,170	260,964	246,538	8,580	25,703	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.305020	0.012265	0.069277	0.000016	1.849669	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: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,388,301		21,388,301	0	21,388,301	30.00
31.00	03100	INTENSIVE CARE UNIT	3,778,703		3,778,703	0	3,778,703	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,895,443		2,895,443	0	2,895,443	35.00
43.00	04300	NURSERY	2,624,756		2,624,756	0	2,624,756	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,331,618		17,331,618	0	17,331,618	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,476,136		5,476,136	0	5,476,136	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,121,222		5,121,222	11,994	5,133,216	54.00
54.01	03480	ONCOLOGY	0		0	0	0	54.01
54.02	05402	ULTRASOUND	988,774		988,774	0	988,774	54.02
57.00	05700	CT SCAN	1,532,689		1,532,689	0	1,532,689	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,472,787		1,472,787	0	1,472,787	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,146,917		4,146,917	0	4,146,917	60.00
65.00	06500	RESPIRATORY THERAPY	1,671,548	0	1,671,548	0	1,671,548	65.00
66.00	06600	PHYSICAL THERAPY	1,016,793	0	1,016,793	0	1,016,793	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,323	0	11,323	0	11,323	68.00
69.00	06900	ELECTROCARDIOLOGY	212,178		212,178	0	212,178	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,391		21,391	0	21,391	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,774,000		6,774,000	0	6,774,000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,674,394		8,674,394	0	8,674,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,896,369		7,896,369	0	7,896,369	73.00
75.00	07500	ASC (NON-DISTINCT PART)	13,466,286		13,466,286	0	13,466,286	75.00
76.00	03330	ENDOSCOPY	5,756,452		5,756,452	0	5,756,452	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,641,869		4,641,869	19,546	4,661,415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,114,670		3,114,670		3,114,670	92.00
200.00		Subtotal (see instructions)	120,014,619	0	120,014,619	31,540	120,046,159	200.00
201.00		Less Observation Beds	3,114,670		3,114,670		3,114,670	201.00
202.00		Total (see instructions)	116,899,949	0	116,899,949	31,540	116,931,489	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,228,902		41,228,902			30.00
31.00	03100	INTENSIVE CARE UNIT	9,087,219		9,087,219			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	15,428,069		15,428,069			35.00
43.00	04300	NURSERY	8,261,592		8,261,592			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	66,303,778	110,439,996	176,743,774	0.098061	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,198,046	916,180	35,114,226	0.155952	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,552,036	26,493,091	29,045,127	0.176319	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	54.01
54.02	05402	ULTRASOUND	472,290	2,815,604	3,287,894	0.300732	0.000000	54.02
57.00	05700	CT SCAN	1,565,443	7,453,569	9,019,012	0.169940	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	142,580	3,188,959	3,331,539	0.442074	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	16,963,121	23,139,412	40,102,533	0.103408	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,057,511	827,550	4,885,061	0.342175	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,277,051	1,795,168	3,072,219	0.330964	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	74,338	28,309	102,647	0.110310	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	855,360	4,845,169	5,700,529	0.037221	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	627,710	682,355	1,310,065	0.016328	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,990,021	36,284,254	49,274,275	0.137475	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,871,089	5,660,864	22,531,953	0.384982	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,696,478	12,764,635	31,461,113	0.250988	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	119,977	60,820,991	60,940,968	0.220973	0.000000	75.00
76.00	03330	ENDOSCOPY	2,002,275	45,807,125	47,809,400	0.120404	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,365,909	38,058,675	44,424,584	0.104489	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,251,469	7,123,031	8,374,500	0.371923	0.000000	92.00
200.00		Subtotal (see instructions)	261,392,264	389,144,937	650,537,201			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	261,392,264	389,144,937	650,537,201			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		35.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.098061	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.155952	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176732	54.00
54.01	03480	ONCOLOGY	0.000000	54.01
54.02	05402	ULTRASOUND	0.300732	54.02
57.00	05700	CT SCAN	0.169940	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.442074	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.103408	60.00
65.00	06500	RESPIRATORY THERAPY	0.342175	65.00
66.00	06600	PHYSICAL THERAPY	0.330964	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.110310	68.00
69.00	06900	ELECTROCARDIOLOGY	0.037221	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.016328	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.137475	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.384982	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.250988	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.220973	75.00
76.00	03330	ENDOSCOPY	0.120404	76.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.104929	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.371923	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/25/2019 8:07 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,388,301		21,388,301	0	21,388,301	30.00
31.00	03100	INTENSIVE CARE UNIT	3,778,703		3,778,703	0	3,778,703	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,895,443		2,895,443	0	2,895,443	35.00
43.00	04300	NURSERY	2,624,756		2,624,756	0	2,624,756	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,331,618		17,331,618	0	17,331,618	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,476,136		5,476,136	0	5,476,136	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,121,222		5,121,222	11,994	5,133,216	54.00
54.01	03480	ONCOLOGY	0		0	0	0	54.01
54.02	05402	ULTRASOUND	988,774		988,774	0	988,774	54.02
57.00	05700	CT SCAN	1,532,689		1,532,689	0	1,532,689	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,472,787		1,472,787	0	1,472,787	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,146,917		4,146,917	0	4,146,917	60.00
65.00	06500	RESPIRATORY THERAPY	1,671,548	0	1,671,548	0	1,671,548	65.00
66.00	06600	PHYSICAL THERAPY	1,016,793	0	1,016,793	0	1,016,793	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,323	0	11,323	0	11,323	68.00
69.00	06900	ELECTROCARDIOLOGY	212,178		212,178	0	212,178	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,391		21,391	0	21,391	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,774,000		6,774,000	0	6,774,000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,674,394		8,674,394	0	8,674,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,896,369		7,896,369	0	7,896,369	73.00
75.00	07500	ASC (NON-DISTINCT PART)	13,466,286		13,466,286	0	13,466,286	75.00
76.00	03330	ENDOSCOPY	5,756,452		5,756,452	0	5,756,452	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,641,869		4,641,869	19,546	4,661,415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,114,670		3,114,670		3,114,670	92.00
200.00		Subtotal (see instructions)	120,014,619	0	120,014,619	31,540	120,046,159	200.00
201.00		Less Observation Beds	3,114,670		3,114,670		3,114,670	201.00
202.00		Total (see instructions)	116,899,949	0	116,899,949	31,540	116,931,489	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I | Date/Time Prepared: 11/25/2019 8:07 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,228,902		41,228,902			30.00
31.00	03100	INTENSIVE CARE UNIT	9,087,219		9,087,219			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	15,428,069		15,428,069			35.00
43.00	04300	NURSERY	8,261,592		8,261,592			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	66,303,778	110,439,996	176,743,774	0.098061	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,198,046	916,180	35,114,226	0.155952	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,552,036	26,493,091	29,045,127	0.176319	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	54.01
54.02	05402	ULTRASOUND	472,290	2,815,604	3,287,894	0.300732	0.000000	54.02
57.00	05700	CT SCAN	1,565,443	7,453,569	9,019,012	0.169940	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	142,580	3,188,959	3,331,539	0.442074	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	16,963,121	23,139,412	40,102,533	0.103408	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,057,511	827,550	4,885,061	0.342175	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,277,051	1,795,168	3,072,219	0.330964	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	74,338	28,309	102,647	0.110310	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	855,360	4,845,169	5,700,529	0.037221	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	627,710	682,355	1,310,065	0.016328	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,990,021	36,284,254	49,274,275	0.137475	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,871,089	5,660,864	22,531,953	0.384982	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,696,478	12,764,635	31,461,113	0.250988	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	119,977	60,820,991	60,940,968	0.220973	0.000000	75.00
76.00	03330	ENDOSCOPY	2,002,275	45,807,125	47,809,400	0.120404	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,365,909	38,058,675	44,424,584	0.104489	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,251,469	7,123,031	8,374,500	0.371923	0.000000	92.00
200.00		Subtotal (see instructions)	261,392,264	389,144,937	650,537,201			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	261,392,264	389,144,937	650,537,201			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/25/2019 8:07 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		35.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03480	ONCOLOGY	0.000000	54.01
54.02	05402	ULTRASOUND	0.000000	54.02
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
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
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
76.00	03330	ENDOSCOPY	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part I Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,930,182	0	2,930,182	14,915	196.46	30.00
31.00	INTENSIVE CARE UNIT	413,985		413,985	1,249	331.45	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	319,941		319,941	2,129	150.28	35.00
43.00	NURSERY	426,141		426,141	3,080	138.36	43.00
200.00	Total (lines 30 through 199)	4,090,249		4,090,249	21,373		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	4,020	789,769	30.00
31.00	INTENSIVE CARE UNIT	569	188,595	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0	35.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	4,589	978,364	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part II Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,606,352	176,743,774	0.014746	23,156,857	341,471	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	640,356	35,114,226	0.018236	11,749	214	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	789,213	29,045,127	0.027172	633,040	17,201	54.00
54.01	03480	ONCOLOGY	0	0	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	172,010	3,287,894	0.052316	160,514	8,397	54.02
57.00	05700	CT SCAN	331,481	9,019,012	0.036754	703,800	25,867	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	440,063	3,331,539	0.132090	63,576	8,398	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	244,152	40,102,533	0.006088	5,475,974	33,338	60.00
65.00	06500	RESPIRATORY THERAPY	177,527	4,885,061	0.036341	1,641,384	59,650	65.00
66.00	06600	PHYSICAL THERAPY	86,432	3,072,219	0.028133	609,554	17,149	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	974	102,647	0.009489	37,741	358	68.00
69.00	06900	ELECTROCARDIOLOGY	27,210	5,700,529	0.004773	563,801	2,691	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,311	1,310,065	0.001001	373,163	374	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	243,005	49,274,275	0.004932	3,128,824	15,431	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	313,024	22,531,953	0.013892	8,275,200	114,959	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	372,953	31,461,113	0.011854	5,411,423	64,147	73.00
75.00	07500	ASC (NON-DISTINCT PART)	973,949	60,940,968	0.015982	0	0	75.00
76.00	03330	ENDOSCOPY	570,879	47,809,400	0.011941	509,225	6,081	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	589,818	44,424,584	0.013277	2,811,630	37,330	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	426,707	8,374,500	0.050953	516,644	26,325	92.00
200.00		Total (lines 50 through 199)	9,007,416	576,531,419		54,084,099	779,381	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part III Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
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	14,915	0.00	4,020	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,249	0.00	569	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	2,129	0.00	0	35.00
43.00	04300	NURSERY		0	3,080	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	21,373		4,589	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	35.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	0	0	0	0	54.02
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV | Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	176,743,774	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	35,114,226	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,045,127	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0.000000	54.01
54.02	05402	ULTRASOUND	0	0	0	3,287,894	0.000000	54.02
57.00	05700	CT SCAN	0	0	0	9,019,012	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,331,539	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	40,102,533	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,885,061	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,072,219	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	102,647	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,700,529	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,310,065	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49,274,275	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,531,953	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	31,461,113	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	60,940,968	0.000000	75.00
76.00	03330	ENDOSCOPY	0	0	0	47,809,400	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	44,424,584	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,374,500	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	576,531,419		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV | Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	23,156,857	0	14,002,709	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	11,749	0	7,808	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	633,040	0	1,730,467	0	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.000000	160,514	0	764,813	0	54.02
57.00	05700	CT SCAN	0.000000	703,800	0	2,016,849	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	63,576	0	731,380	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	5,475,974	0	5,069,761	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,641,384	0	426,417	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	609,554	0	52,127	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	37,741	0	2,479	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	563,801	0	1,220,887	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	373,163	0	113,223	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	3,128,824	0	1,704,423	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	8,275,200	0	570,934	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,411,423	0	3,331,961	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0.000000	509,225	0	4,866,026	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	2,811,630	0	7,352,015	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	516,644	0	2,066,449	0	92.00
200.00		Total (lines 50 through 199)		54,084,099	0	46,030,728	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V | Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.098061	14,002,709	0	0	1,373,120	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.155952	7,808	0	0	1,218	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176319	1,730,467	0	0	305,114	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.300732	764,813	0	0	230,004	54.02
57.00	05700	CT SCAN	0.169940	2,016,849	0	0	342,743	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.442074	731,380	0	0	323,324	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.103408	5,069,761	0	0	524,254	60.00
65.00	06500	RESPIRATORY THERAPY	0.342175	426,417	0	0	145,909	65.00
66.00	06600	PHYSICAL THERAPY	0.330964	52,127	0	0	17,252	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.110310	2,479	0	0	273	68.00
69.00	06900	ELECTROCARDIOLOGY	0.037221	1,220,887	0	0	45,443	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.016328	113,223	0	0	1,849	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.137475	1,704,423	0	0	234,316	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.384982	570,934	0	0	219,799	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.250988	3,331,961	0	58,858	836,282	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.220973	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0.120404	4,866,026	0	0	585,889	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.104489	7,352,015	0	0	768,205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.371923	2,066,449	0	0	768,560	92.00
200.00		Subtotal (see instructions)		46,030,728	0	58,858	6,723,554	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		46,030,728	0	58,858	6,723,554	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03480	ONCOLOGY	0	0	54.01
54.02	05402	ULTRASOUND	0	0	54.02
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
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	14,773	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03330	ENDOSCOPY	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	14,773	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	14,773	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V Date/Time Prepared: 11/25/2019 8:07 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.098061	0	10,647,056	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.155952	0	190,189	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176319	0	1,386,076	0	0	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.300732	0	266,554	0	0	54.02
57.00	05700	CT SCAN	0.169940	0	573,340	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.442074	0	207,926	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.103408	0	2,695,683	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.342175	0	217,660	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.330964	0	162,046	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.110310	0	610	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.037221	0	257,315	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.016328	0	91,144	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.137475	0	2,686,996	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.384982	0	491,142	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.250988	0	1,065,382	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.220973	0	10,623,732	0	0	75.00
76.00	03330	ENDOSCOPY	0.120404	0	2,941,900	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.104489	0	4,935,821	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.371923	0	725,411	0	0	92.00
200.00		Subtotal (see instructions)		0	40,165,983	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	40,165,983	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V Date/Time Prepared: 11/25/2019 8:07 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,044,061	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,660	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	244,392	0	54.00
54.01	03480	ONCOLOGY	0	0	54.01
54.02	05402	ULTRASOUND	80,161	0	54.02
57.00	05700	CT SCAN	97,433	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	91,919	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	278,755	0	60.00
65.00	06500	RESPIRATORY THERAPY	74,478	0	65.00
66.00	06600	PHYSICAL THERAPY	53,631	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	67	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,578	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,488	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	369,395	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	189,081	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	267,398	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,347,558	0	75.00
76.00	03330	ENDOSCOPY	354,217	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	515,739	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	269,797	0	92.00
200.00		Subtotal (see instructions)	6,318,808	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	6,318,808	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/25/2019 8:07 am

	Title XVIII	Hospital	PPS	
	Cost Center Description			
			1.00	
	PART I - ALL PROVIDER COMPONENTS			
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,915	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,915	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)		12,743	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)		4,020	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)		21,388,301	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)		21,388,301	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)		21,388,301	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)		1,434.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,764,720	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)		5,764,720	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,778,703	1,249	3,025.38	569	1,721,441	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	NEONATAL INTENSIVE CARE UNIT	2,895,443	2,129	1,360.00	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	9,463,985	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	16,950,146	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)	978,364	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	779,381	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,757,745	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	15,192,401	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)	2,172	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,434.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,114,670	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/25/2019 8:07 am
	Title XVIII	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,930,182	21,388,301	0.136999	3,114,670	426,707	90.00
91.00	Nursing School cost	0	21,388,301	0.000000	3,114,670	0	91.00
92.00	Allied health cost	0	21,388,301	0.000000	3,114,670	0	92.00
93.00	All other Medical Education	0	21,388,301	0.000000	3,114,670	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/25/2019 8:07 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,915	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,915	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)	12,743	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)	256	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)	3,080	15.00
16.00	Nursery days (title V or XIX only)	96	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)	21,388,301	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)	21,388,301	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)	21,388,301	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)	1,434.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	367,107	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)	367,107	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/25/2019 8:07 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2,624,756	3,080	852.19	96	81,810	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,778,703	1,249	3,025.38	158	478,010	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	NEONATAL INTENSIVE CARE UNIT	2,895,443	2,129	1,360.00	308	418,880	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,119,401	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,465,208	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)	2,172	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,434.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,114,670	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/25/2019 8:07 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,930,182	21,388,301	0.136999	3,114,670	426,707	90.00
91.00	Nursing School cost	0	21,388,301	0.000000	3,114,670	0	91.00
92.00	Allied health cost	0	21,388,301	0.000000	3,114,670	0	92.00
93.00	All other Medical Education	0	21,388,301	0.000000	3,114,670	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/25/2019 8:07 am
	Title XVIII	Hospital	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		10,242,866		30.00
31.00	03100	INTENSIVE CARE UNIT		5,931,421		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0		35.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.098061	23,156,857	2,270,785	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.155952	11,749	1,832	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176732	633,040	111,878	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	0.300732	160,514	48,272	54.02
57.00	05700	CT SCAN	0.169940	703,800	119,604	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.442074	63,576	28,105	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.103408	5,475,974	566,260	60.00
65.00	06500	RESPIRATORY THERAPY	0.342175	1,641,384	561,641	65.00
66.00	06600	PHYSICAL THERAPY	0.330964	609,554	201,740	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.110310	37,741	4,163	68.00
69.00	06900	ELECTROCARDIOLOGY	0.037221	563,801	20,985	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.016328	373,163	6,093	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.137475	3,128,824	430,135	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.384982	8,275,200	3,185,803	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.250988	5,411,423	1,358,202	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.220973	0	0	75.00
76.00	03330	ENDOSCOPY	0.120404	509,225	61,313	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.104929	2,811,630	295,022	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.371923	516,644	192,152	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		54,084,099	9,463,985	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)		54,084,099		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/25/2019 8:07 am
	Title XIX	Hospital	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,053,868		30.00
31.00	03100	INTENSIVE CARE UNIT		985,106		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		4,107,248		35.00
43.00	04300	NURSERY		633,615		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.098061	6,632,838	650,423	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.155952	3,507,599	547,017	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176319	350,150	61,738	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	0.300732	52,702	15,849	54.02
57.00	05700	CT SCAN	0.169940	142,236	24,172	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.442074	12,456	5,506	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.103408	1,861,300	192,473	60.00
65.00	06500	RESPIRATORY THERAPY	0.342175	411,516	140,810	65.00
66.00	06600	PHYSICAL THERAPY	0.330964	104,100	34,453	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.110310	9,951	1,098	68.00
69.00	06900	ELECTROCARDIOLOGY	0.037221	47,447	1,766	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.016328	11,136	182	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.137475	1,588,084	218,322	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.384982	1,463,751	563,518	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.250988	2,378,025	596,856	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.220973	0	0	75.00
76.00	03330	ENDOSCOPY	0.120404	158,704	19,109	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.104489	441,277	46,109	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.371923	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		19,173,272	3,119,401	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)		19,173,272		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/25/2019 8:07 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	3,375,821	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	10,545,249	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	308,354	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	147.05	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.59	30.00
31.00	Percentage of Medicaid patient days (see instructions)	16.44	31.00
32.00	Sum of lines 30 and 31	18.03	32.00
33.00	Allowable disproportionate share percentage (see instructions)	4.47	33.00
34.00	Disproportionate share adjustment (see instructions)	155,568	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/25/2019 8:07 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000090058	0.000131448	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	609,395	1,087,453	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	153,601	813,355	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	966,956		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	15,351,948		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	15,351,948	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,234,094	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	16,586,042	59.00
60.00	Primary payer payments	7,478	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	16,578,564	61.00
62.00	Deductibles billed to program beneficiaries	1,331,828	62.00
63.00	Coinsurance billed to program beneficiaries	15,458	63.00
64.00	Allowable bad debts (see instructions)	29,951	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	19,468	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	18,956	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	15,250,746	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	107,742	70.93
70.94	HRR adjustment amount (see instructions)	-6,327	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E Part A Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		15,352,161	71.00
71.01	Sequestration adjustment (see instructions)		307,043	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		14,896,371	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		148,747	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		48,025	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0157

Period: From 07/01/2018 To 06/30/2019

Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/25/2019 8:07 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,375,821	0	3,375,821		3,375,821	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,545,249	0		10,545,249	10,545,249	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	308,354	0	0	308,354	308,354	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0447	0.0447	0.0447	0.0447		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	155,568	0	37,725	117,843	155,568	11.00
11.01	Uncompensated care payments	36.00	966,956	0	153,601	813,355	966,956	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,351,948	0	3,567,147	11,784,801	15,351,948	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,351,948	0	3,567,147	11,784,801	15,351,948	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,234,094	0	303,474	930,620	1,234,094	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,870,621	12,715,421	16,586,042	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,132,990	0	274,994	857,996	1,132,990	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	58,957	0	18,250	40,707	58,957	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0372	0.0372	0.0372	0.0372		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	42,147	0	10,230	31,917	42,147	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,234,094	0	303,474	930,620	1,234,094	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,375,821	3,375,821		3,375,821	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,545,249		10,545,249	10,545,249	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	308,354	0	308,354	308,354	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0447	0.0447	0.0447		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	155,568	37,725	117,843	155,568	11.00
11.01	Uncompensated care payments	36.00	966,956	153,601	813,355	966,956	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,351,948	3,567,147	11,784,801	15,351,948	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,351,948	3,567,147	11,784,801	15,351,948	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,234,094	303,474	930,620	1,234,094	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			3,870,621	12,715,421	16,586,042	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,132,990	274,994	857,996	1,132,990	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	58,957	18,250	40,707	58,957	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0372	0.0372	0.0372		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	42,147	10,230	31,917	42,147	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,234,094	303,474	930,620	1,234,094	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	107,742	4,213	103,529	107,742	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-6,327	0	-6,327	-6,327	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/25/2019 8:07 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	14,773	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,723,554	2.00
3.00	OPPS payments	6,379,450	3.00
4.00	Outlier payment (see instructions)	87,456	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)	14,773	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	58,858	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)	58,858	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)	58,858	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	44,085	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)	14,773	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)	6,466,906	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)	1,278,804	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)	5,202,875	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)	5,202,875	30.00
31.00	Primary payer payments	362	31.00
32.00	Subtotal (line 30 minus line 31)	5,202,513	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)	100,010	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	65,007	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	92,791	36.00
37.00	Subtotal (see instructions)	5,267,520	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)	5,267,520	40.00
40.01	Sequestration adjustment (see instructions)	105,350	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	5,084,783	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	77,387	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: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E-1 Part I Date/Time Prepared: 11/25/2019 8:07 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		14,896,371		5,084,783	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		14,896,371		5,084,783	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		148,747		77,387	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		15,045,118		5,162,170	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet E-1 Part II Date/Time Prepared: 11/25/2019 8:07 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E-3 Part VII Date/Time Prepared: 11/25/2019 8:07 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	4,465,208		1.00
2.00	Medical and other services		6,318,808	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	4,465,208	6,318,808	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)	4,465,208	6,318,808	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	5,053,868		8.00
9.00	Ancillary service charges	19,173,272	40,165,983	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)	24,227,140	40,165,983	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)	24,227,140	40,165,983	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	19,761,932	33,847,175	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)	4,465,208	6,318,808	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)	4,465,208	6,318,808	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)	4,465,208	6,318,808	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)	4,465,208	6,318,808	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	4,465,208	6,318,808	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)	4,465,208	6,318,808	40.00
41.00	Interim payments	4,465,208	6,318,808	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: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet G Date/Time Prepared: 11/25/2019 8:07 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6,567,143	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	63,384,299	0	0	0	4.00
5.00	Other receivable	3,830,804	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-27,999,116	0	0	0	6.00
7.00	Inventory	2,585,718	0	0	0	7.00
8.00	Prepaid expenses	158,995	0	0	0	8.00
9.00	Other current assets	240,198	0	0	0	9.00
10.00	Due from other funds	11,869,605	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	60,637,646	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	15,676,014	0	0	0	12.00
13.00	Land improvements	2,564,800	0	0	0	13.00
14.00	Accumulated depreciation	-2,249,872	0	0	0	14.00
15.00	Buildings	83,678,549	0	0	0	15.00
16.00	Accumulated depreciation	-50,046,929	0	0	0	16.00
17.00	Leasehold improvements	3,288,035	0	0	0	17.00
18.00	Accumulated depreciation	-2,498,704	0	0	0	18.00
19.00	Fixed equipment	16,127,482	0	0	0	19.00
20.00	Accumulated depreciation	-4,966,533	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	46,709,097	0	0	0	23.00
24.00	Accumulated depreciation	-36,059,447	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)	72,222,492	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	238,848	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	24,458,847	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	24,458,847	238,848	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	157,318,985	238,848	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,886,175	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,088,267	0	0	0	38.00
39.00	Payroll taxes payable	411,463	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	15,772,249	0	0	0	43.00
44.00	Other current liabilities	8,455,962	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	30,614,116	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	19,329,995	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,329,995	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	49,944,111	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	107,374,874				52.00
53.00	Specific purpose fund		238,848			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)	107,374,874	238,848	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	157,318,985	238,848	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G-1 Date/Time Prepared: 11/25/2019 8:07 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		104,556,455		236,075		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		99,071,359				2.00
3.00	Total (sum of line 1 and line 2)		203,627,814		236,075		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	OTHER ACTIVITY	0		2,773		0	5.00
6.00	TRANSFER TO AFFILIATE	72,690		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)		72,690		2,773		10.00
11.00	Subtotal (line 3 plus line 10)		203,700,504		238,848		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFER TO AFFILIATES	0		0		0	13.00
14.00	DISTRIBUTIONS	10,267,210		0		0	14.00
15.00	NET ASSETS TRANS TO FROM ALPHA	86,058,417		0		0	15.00
16.00	ROUNDING	3		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		96,325,630		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		107,374,874		238,848		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	OTHER ACTIVITY		0		5.00
6.00	TRANSFER TO AFFILIATE		0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00	TRANSFER TO AFFILIATES		0		13.00
14.00	DISTRIBUTIONS		0		14.00
15.00	NET ASSETS TRANS TO FROM ALPHA		0		15.00
16.00	ROUNDING		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: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/25/2019 8:07 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	47,037,700		47,037,700	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)	47,037,700		47,037,700	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	9,087,219		9,087,219	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	NEONATAL INTENSIVE CARE UNIT	15,428,069		15,428,069	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	24,515,288		24,515,288	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	71,552,988		71,552,988	17.00
18.00	Ancillary services	182,221,919	347,269,865	529,491,784	18.00
19.00	Outpatient services	7,617,378	41,875,073	49,492,451	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	PHYSICIAN PRIVATE OFFICES	0	3,248,002	3,248,002	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	261,392,285	392,392,940	653,785,225	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		136,402,605		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)		136,402,605		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G-3 Date/Time Prepared: 11/25/2019 8:07 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	653,785,225	1.00
2.00	Less contractual allowances and discounts on patients' accounts	425,751,752	2.00
3.00	Net patient revenues (line 1 minus line 2)	228,033,473	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	136,402,605	4.00
5.00	Net income from service to patients (line 3 minus line 4)	91,630,868	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	407,479	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	-154,055	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	2,625	21.00
22.00	Rental of hospital space	742,179	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEALS ON WHEELS	1,929	24.00
24.01	CONTRACT SERVICES REVENUE	913,239	24.01
24.02	OTHER MISCELLANEOUS REVENUE	865,676	24.02
24.03	LATE PENALTY FEES	368	24.03
24.04	OTHER NONOPERATING	1,462	24.04
24.05	CONSOLIDATING AMOUNT	2,771,086	24.05
24.06	SEMINARS TUITION REVENUE	3,865	24.06
24.07	MEDICAL AFFAIRS ADMIN - ADMINISTRATI	31	24.07
24.08	GAIN ON SALE OF PPE	4,980	24.08
24.09	INTRA/INTERCOMPANY OPERATING REVENUE	47,416	24.09
24.10	AUXILIARY/GIFT SHOP INCOME	340,432	24.10
24.11	BILLING ARRANGEMENTS	1,493,365	24.11
24.12	OTHER (SPECIFY)	0	24.12
25.00	Total other income (sum of lines 6-24)	7,442,077	25.00
26.00	Total (line 5 plus line 25)	99,072,945	26.00
27.00	LOSS FROM UNCONSOLIDATED ENTITIES	0	27.00
27.01	INVESTMENT INCOME NONHSD	-94	27.01
27.02	NET ASSETS REL FROM RESTRICTED FUNDS	0	27.02
27.03	DONATIONS	240	27.03
27.04	FUNDRAISING ACTIVITIES	1,200	27.04
27.05	OTHER NONOPERATING INTERESTS	240	27.05
28.00	Total other expenses (sum of line 27 and subscripts)	1,586	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	99,071,359	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0157	Period: From 07/01/2018 To 06/30/2019	Worksheet L Parts I-III Date/Time Prepared: 11/25/2019 8:07 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,132,990	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	58,957	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	48.88	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	1.59	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	16.44	8.00
9.00	Sum of lines 7 and 8	18.03	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.72	10.00
11.00	Disproportionate share adjustment (see instructions)	42,147	11.00
12.00	Total prospective capital payments (see instructions)	1,234,094	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00