This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0075	Period: From 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 2/28/2019 4:45 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report Date: 2/28/2019 Time: 4:45 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BLUFFTON REGIONAL MEDICAL CENTER (15-0075) for the cost reporting period beginning 10/01/2017 and ending 09/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) ______________________
Officer or Administrator of Provider(s)

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	134,851	58,460	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
7.00	SKILLED NURSING FACILITY	0	-1	0		0	7.00
200.00	Total	0	134,850	58,460	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: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2019 4:45 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 S. MAIN STREET	PO Box:			1.00
2.00	City: BLUFFTON	State: IN	Zip Code: 46714-	County: WELLS	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	BLUFFTON REGIONAL MEDICAL CENTER	150075	23060	1	07/01/1966	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	BLUFFTON SKILLED NURSING	155373	23060		03/13/1991	N	P	N	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)	10/01/2017	09/30/2018	20.00
21.00	Type of Control (see instructions)	4		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	622	144	0	0	425	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2019 4:45 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0075	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/28/2019 4:45 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2019 4:45 pm

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

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

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

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

			1.00	
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	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.	Y	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.	Y	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.	Y	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.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			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:	203,659	38,035	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2019 4:45 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: CHS / COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2018	03/31/2018	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

		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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	12/14/2018	Y	12/14/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

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

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2017	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.	KUZIWA	TSIGA	41.00
42.00	Enter the employer/company name of the cost report preparer.	CHS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3416	KUZIWA_TSIGA@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0075	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/28/2019 4:45 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR 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: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 2/28/2019 4:45 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	55	20,075	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)		55	20,075	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		62	22,630	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	44.00	13	4,745		0	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)		75				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: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 2/28/2019 4:45 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,337	622	3,760			1.00
2.00	HMO and other (see instructions)	854	432				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)	1,337	622	3,760			7.00
8.00	INTENSIVE CARE UNIT	222	6	520			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		131	479			13.00
14.00	Total (see instructions)	1,559	759	4,759	0.00	216.71	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	1,405	0	3,137	0.00	12.78	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	229.49	27.00
28.00	Observation Bed Days		0	861			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	203			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: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2019 4:45 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	464	306	1,652	1.00
2.00	HMO and other (see instructions)			244	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	464	306	1,652	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	0.00					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: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 2/28/2019 4:45 pm

		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	13,528,086	0	13,528,086	477,348.00	28.34	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	659,267	0	659,267	26,581.00	24.80	9.00
10.00	Excluded area salaries (see instructions)		6,215	0	6,215	214.00	29.04	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		266,932	0	266,932	4,060.00	65.75	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		94,220	0	94,220	1,048.00	89.90	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		1,085,844	0	1,085,844	31,750.24	34.20	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)		3,112,788	0	3,112,788			17.00
18.00	Wage-related costs (other) (see instructions)		54,527	0	54,527			18.00
19.00	Excluded areas		245,062	0	245,062			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			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	86,616	0	86,616	2,150.00	40.29	26.00
27.00	Administrative & General	5.00	1,893,614	-158,307	1,735,307	62,611.00	27.72	27.00

		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.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	370,831	0	370,831	13,466.00	27.54	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	250,499	0	250,499	16,943.00	14.78	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	408,497	-235,721	172,776	29,168.00	5.92	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	235,721	235,721	17,866.38	13.19	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,185,645	158,307	1,343,952	30,534.00	44.01	38.00
39.00	Central Services and Supply	14.00	150,032	0	150,032	8,547.00	17.55	39.00
40.00	Pharmacy	15.00	527,223	0	527,223	12,622.00	41.77	40.00
41.00	Medical Records & Medical Records Library	16.00	303,755	0	303,755	14,243.00	21.33	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part III Date/Time Prepared: 2/28/2019 4:45 pm

		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)		13,528,086	0	13,528,086	477,348.00	28.34	1.00
2.00	Excluded area salaries (see instructions)		665,482	0	665,482	26,795.00	24.84	2.00
3.00	Subtotal salaries (line 1 minus line 2)		12,862,604	0	12,862,604	450,553.00	28.55	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,446,996	0	1,446,996	36,858.24	39.26	4.00
5.00	Subtotal wage-related costs (see inst.)		3,167,315	0	3,167,315	0.00	24.62	5.00
6.00	Total (sum of lines 3 thru 5)		17,476,915	0	17,476,915	487,411.24	35.86	6.00
7.00	Total overhead cost (see instructions)		5,176,712	0	5,176,712	208,150.38	24.87	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0075	Period: From 10/01/2017 To 09/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 2/28/2019 4:45 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	298,075	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	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)	1,813,029	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	9,220	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	11,987	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	204	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	4,471	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	210,078	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	805,468	17.00
18.00	Medicare Taxes - Employers Portion Only	188,376	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	33,419	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,374,327	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS	54,527	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part V Date/Time Prepared: 2/28/2019 4:45 pm

	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	266,932	3,357,850	1.00
2.00	Hospital	266,932	3,112,788	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	0	243,016	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	2,046	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-7 Date/Time Prepared: 2/28/2019 4:45 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	119	0	119	12.00
13.00	RUB	142	0	142	13.00
14.00	RUA	45	0	45	14.00
15.00	RVC	155	0	155	15.00
16.00	RVB	177	0	177	16.00
17.00	RVA	61	0	61	17.00
18.00	RHC	127	0	127	18.00
19.00	RHB	287	0	287	19.00
20.00	RHA	137	0	137	20.00
21.00	RMC	3	0	3	21.00
22.00	RMB	34	0	34	22.00
23.00	RMA	47	0	47	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	3	0	3	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	4	0	4	31.00
32.00	HD1	3	0	3	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	0	0	0	34.00
35.00	HB2	6	0	6	35.00
36.00	HB1	32	0	32	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	1	0	1	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	0	0	0	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	1	0	1	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	4	0	4	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	6	0	6	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	3	0	3	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-7 Date/Time Prepared: 2/28/2019 4:45 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	8	0	8	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,405	0	1,405	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	23060	23060	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	3,604,204			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0075	Period: From 10/01/2017 To 09/30/2018	Worksheet S-10 Date/Time Prepared: 2/28/2019 4:45 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.150292	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,000,432	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	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	29,974,426	6.00
7.00	Medicaid cost (line 1 times line 6)	4,504,916	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)	504,484	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)	11,190	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	256,003	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	38,475	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)	27,285	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)	531,769	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,678,644	0	2,678,644	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	402,579	0	402,579	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)	402,579	0	402,579	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,241,330	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	75,092	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	115,525	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,125,805	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	209,632	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	612,211	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,143,980	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,078,103	1,078,103	269,394	1,347,497	1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT		0	0	0	0	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,177,080	2,177,080	322,804	2,499,884	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	86,616	45,975	132,591	2,396,283	2,528,874	4.00
5.01	01160	COMMUNICATIONS	0	0	0	543,386	543,386	5.01
5.02	00540	ADMITTING	0	0	0	509,458	509,458	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	1,047,502	1,047,502	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	1,893,614	10,454,702	12,348,316	-5,048,664	7,299,652	5.04
7.00	00700	OPERATION OF PLANT	370,831	1,552,032	1,922,863	381,871	2,304,734	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	143,167	143,167	0	143,167	8.00
9.00	00900	HOUSEKEEPING	250,499	127,760	378,259	-7,273	370,986	9.00
10.00	01000	DIETARY	408,497	372,723	781,220	-460,757	320,463	10.00
11.00	01100	CAFETERIA	0	0	0	450,799	450,799	11.00
13.00	01300	NURSING ADMINISTRATION	1,185,645	221,961	1,407,606	151,057	1,558,663	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	150,032	1,031,542	1,181,574	-536,869	644,705	14.00
15.00	01500	PHARMACY	527,223	1,416,726	1,943,949	-1,223,052	720,897	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303,755	287,148	590,903	-5,274	585,629	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,044,093	1,308,904	3,352,997	-824,724	2,528,273	30.00
31.00	03100	INTENSIVE CARE UNIT	483,412	139,916	623,328	-3,761	619,567	31.00
43.00	04300	NURSERY	0	0	0	586,520	586,520	43.00
44.00	04400	SKILLED NURSING FACILITY	659,267	120,653	779,920	-2,914	777,006	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,081,994	1,172,220	2,254,214	-1,183	2,253,031	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	189,728	189,728	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	937,279	328,112	1,265,391	-162,978	1,102,413	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	65,464	79,942	145,406	-434	144,972	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	845,417	881,978	1,727,395	-78,049	1,649,346	60.00
65.00	06500	RESPIRATORY THERAPY	330,679	41,423	372,102	-2,688	369,414	65.00
66.00	06600	PHYSICAL THERAPY	819,348	88,933	908,281	-3,560	904,721	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	49,173	3,461	52,634	0	52,634	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	140,087	140,087	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	321,198	321,198	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,062,153	1,062,153	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	111,710	17,515	129,225	0	129,225	76.01
76.03	03953	WOUND CARE	51,121	14,875	65,996	-1,268	64,728	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	51,967	14,630	66,597	-540	66,057	90.00
91.00	09100	EMERGENCY	814,235	432,196	1,246,431	-8,168	1,238,263	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,521,871	23,553,677	37,075,548	84	37,075,632	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,415	10,415	-84	10,331	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	6,215	3,774	9,989	0	9,989	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	13,528,086	23,567,866	37,095,952	0	37,095,952	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	166,206	1,513,703	1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	0	0	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	165,837	2,665,721	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-922	2,527,952	4.00
5.01	01160	COMMUNICATIONS	-30,436	512,950	5.01
5.02	00540	ADMITTING	0	509,458	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	1,047,502	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	-2,047,007	5,252,645	5.04
7.00	00700	OPERATION OF PLANT	0	2,304,734	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	143,167	8.00
9.00	00900	HOUSEKEEPING	0	370,986	9.00
10.00	01000	DIETARY	0	320,463	10.00
11.00	01100	CAFETERIA	-29,726	421,073	11.00
13.00	01300	NURSING ADMINISTRATION	-31,402	1,527,261	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	644,705	14.00
15.00	01500	PHARMACY	0	720,897	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-455	585,174	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-801,969	1,726,304	30.00
31.00	03100	INTENSIVE CARE UNIT	0	619,567	31.00
43.00	04300	NURSERY	0	586,520	43.00
44.00	04400	SKILLED NURSING FACILITY	0	777,006	44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-868,343	1,384,688	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	189,728	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-25,921	1,076,492	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	144,972	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	1,649,346	60.00
65.00	06500	RESPIRATORY THERAPY	0	369,414	65.00
66.00	06600	PHYSICAL THERAPY	0	904,721	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	52,634	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	140,087	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	321,198	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,062,153	73.00
76.00	03950	OTHER ANCILLARY	0	0	76.00
76.01	03951	SLEEP LAB	0	129,225	76.01
76.03	03953	WOUND CARE	0	64,728	76.03
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	66,057	90.00
91.00	09100	EMERGENCY	-205,196	1,033,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0	95.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,709,334	33,366,298	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,331	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	194.00
194.01	07955	MARKETING	0	0	194.01
194.02	07952	SENIOR CIRCLE	-1,740	8,249	194.02
194.03	07953	BUSINESS HEALTH	0	0	194.03
194.04	07954	VACANT SPACE	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,711,074	33,384,878	200.00

RECLASSIFICATIONS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/28/2019 4:45 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,401,592	1.00
	TOTALS		0	2,401,592	
	C - RECLASS RENTAL AND LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	33,974	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	316,129	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	TOTALS		0	350,103	
	D - RECLASS OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	57,128	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	178,292	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,675	3.00
	TOTALS		0	242,095	
	E - RECLASS REPAIRS & MAINTENANCE				
1.00	OPERATION OF PLANT	7.00	0	396,151	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	TOTALS		0	396,151	
	F - RECLASS CNO COSTS				
1.00	NURSING ADMINISTRATION	13.00	158,307	0	1.00
	TOTALS		158,307	0	
	G - RECLASS MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	140,087	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	321,198	2.00
3.00	OPERATING ROOM	50.00	0	49,538	3.00
	TOTALS		0	510,823	
	H - RECLASS COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,062,153	1.00
	TOTALS		0	1,062,153	
	I - RECLASS LABOR AND DELIVERY COSTS				
1.00	NURSERY	43.00	432,504	154,016	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	139,907	49,821	2.00
	TOTALS		572,411	203,837	
	L - RECLASS A PORTION OF DIETARY TO CAFE				
1.00	CAFETERIA	11.00	235,721	215,078	1.00
	TOTALS		235,721	215,078	

RECLASSIFICATIONS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/28/2019 4:45 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	M - RECLASS ADMIN AND GENERAL COSTS				
1.00	COMMUNICATIONS	5.01	52,337	491,049	1.00
2.00	ADMITTING	5.02	451,761	57,697	2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	70,251	977,251	3.00
	TOTALS		574,349	1,525,997	
500.00	Grand Total: Increases		1,540,788	6,907,829	500.00

RECLASSIFICATIONS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/28/2019 4:45 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - RECLASS EMPLOYEE BENEFITS					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	2,401,592	0	1.00
	TOTALS		0	2,401,592		
	C - RECLASS RENTAL AND LEASE EXPENSE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,294	10	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	11,606	10	2.00
3.00	OPERATION OF PLANT	7.00	0	14,280	0	3.00
4.00	HOUSEKEEPING	9.00	0	793	0	4.00
5.00	DIETARY	10.00	0	1,102	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	1,314	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	14,069	0	7.00
8.00	PHARMACY	15.00	0	124,776	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,588	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	19,877	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	898	0	11.00
12.00	SKILLED NURSING FACILITY	44.00	0	1,918	0	12.00
13.00	OPERATING ROOM	50.00	0	1,711	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	130,816	0	14.00
15.00	LABORATORY	60.00	0	15,101	0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	323	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	2,283	0	17.00
18.00	WOUND CARE	76.03	0	1,186	0	18.00
19.00	CLINIC	90.00	0	540	0	19.00
20.00	EMERGENCY	91.00	0	1,544	0	20.00
21.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	84	0	21.00
	TOTALS		0	350,103		
	D - RECLASS OTHER CAPITAL COSTS					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	242,095	12	1.00
2.00		0.00	0	0	13	2.00
3.00		0.00	0	0	12	3.00
	TOTALS		0	242,095		
	E - RECLASS REPAIRS & MAINTENANCE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,015	0	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	134,718	0	2.00
3.00	HOUSEKEEPING	9.00	0	6,480	0	3.00
4.00	DIETARY	10.00	0	8,856	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	5,936	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	11,977	0	6.00
7.00	PHARMACY	15.00	0	36,123	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,686	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	28,599	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	2,863	0	10.00
11.00	SKILLED NURSING FACILITY	44.00	0	996	0	11.00
12.00	OPERATING ROOM	50.00	0	49,010	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	32,162	0	13.00
14.00	RADIOISOTOPE	56.00	0	434	0	14.00
15.00	LABORATORY	60.00	0	62,948	0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	2,365	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	1,277	0	17.00
18.00	WOUND CARE	76.03	0	82	0	18.00
19.00	EMERGENCY	91.00	0	6,624	0	19.00
	TOTALS		0	396,151		
	F - RECLASS CNO COSTS					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	158,307	0	0	1.00
	TOTALS		158,307	0		
	G - RECLASS MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	510,823	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	510,823		
	H - RECLASS COST OF DRUGS/IV SOLUTIONS					
1.00	PHARMACY	15.00	0	1,062,153	0	1.00
	TOTALS		0	1,062,153		
	I - RECLASS LABOR AND DELIVERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	572,411	203,837	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		572,411	203,837		

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	L - RECLASS A PORTION OF DIETARY TO CAFE					
1.00	DIETARY	10.00	235,721	215,078	0	1.00
	TOTALS		235,721	215,078		
	M - RECLASS ADMIN AND GENERAL COSTS					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	574,349	1,525,997	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		574,349	1,525,997		
500.00	Grand Total: Decreases		1,540,788	6,907,829		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 2/28/2019 4:45 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,844,900	0	0	0	0	1.00
2.00	Land Improvements	748,002	0	0	0	28,978	2.00
3.00	Buildings and Fixtures	20,252,745	469	0	469	0	3.00
4.00	Building Improvements	5,409,502	1,797,969	0	1,797,969	10,929	4.00
5.00	Fixed Equipment	3,972,799	47,847	0	47,847	1,529,273	5.00
6.00	Movable Equipment	18,716,650	992,558	0	992,558	1,861,837	6.00
7.00	HIT designated Assets	4,206,037	1,389,412	0	1,389,412	4,155	7.00
8.00	Subtotal (sum of lines 1-7)	57,150,635	4,228,255	0	4,228,255	3,435,172	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	57,150,635	4,228,255	0	4,228,255	3,435,172	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,844,900	0	1.00
2.00	Land Improvements	719,024	0	2.00
3.00	Buildings and Fixtures	20,253,214	0	3.00
4.00	Building Improvements	7,196,542	0	4.00
5.00	Fixed Equipment	2,491,373	0	5.00
6.00	Movable Equipment	17,847,371	0	6.00
7.00	HIT designated Assets	5,591,294	0	7.00
8.00	Subtotal (sum of lines 1-7)	57,943,718	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	57,943,718	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part II Date/Time Prepared: 2/28/2019 4:45 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,078,103	0	0	0	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	2,177,080	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,255,183	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,078,103	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,177,080	2.00
3.00	Total (sum of lines 1-2)	0	3,255,183	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 2/28/2019 4:45 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	38,433,983	0	38,433,983	0.672503	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	18,716,650	0	18,716,650	0.327497	0	2.00
3.00	Total (sum of lines 1-2)	57,150,633	0	57,150,633	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	1,095,088	33,974	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,234,521	316,129	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,329,609	350,103	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	125,329	57,128	178,292	23,892	1,513,703	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,675	0	108,396	2,665,721	2.00
3.00	Total (sum of lines 1-2)	125,329	63,803	178,292	132,288	4,179,424	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 2/28/2019 4:45 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - WELLS CRC COSTS-BLDG & FIXT (chapter 2)		0	WELLS CRC COSTS-BLDG & FIXT	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-30,436	COMMUNICATIONS	5.01	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,057,025			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	-896,848			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-29,726	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-455	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	16,985	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - WELLS CRC COSTS-BLDG & FIXT		0	WELLS CRC COSTS-BLDG & FIXT	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	57,441	CAP REL COSTS-MVBLE EQUIP	2.00	9	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 2/28/2019 4:45 pm

				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	
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	INSERVICE EDUCATION	B	-24,655	NURSING ADMINISTRATION	13.00	0	33.00
33.01	FITNESS REVENUE	B	-517,826	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.01
33.02	OTHER MISC REVENUE	B	-23,552	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.02
33.03	SENIOR CIRCLE	B	-1,740	SENIOR CIRCLE	194.02	0	33.03
33.04	PATIENT PHONES BENEFITS	A	-922	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MARKETING	A	-9,425	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.05
33.06	LOBBYING EXPENSE	A	-785	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.06
33.07	PHYSICIAN RECRUITING	A	-836	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.07
33.08	CHARITABLE CONTRIBUTIONS	A	-31,850	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	CRNA COSTS	A	-868,343	OPERATING ROOM	50.00	0	33.09
33.10	PENALTIES/LATE FEES	A	-257	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.10
33.11	MEMBERSHIPS/DUES	A	-44,608	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.11
33.12	LEGAL FEES	A	-2,703	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.12
33.13	MARKETING DEPARTMENT	A	-243,508	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,711,074				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: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-1 Date/Time Prepared: 2/28/2019 4:45 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL-RELATED INTEREST	125,329	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	6,924	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	1,204	0	3.00
4.00	5.04	OTHER ADMINISTRATIVE AND GEN	PASI OPERATING COSTS	109,001	168,808	4.00
4.01	5.04	OTHER ADMINISTRATIVE AND GEN	SHARED SERVICE CENTER ALLOCA	446,224	462,378	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	16,968	0	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	107,192	0	4.03
4.04	5.04	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL HOME OFFICE COST	1,085,803	0	4.04
4.05	5.04	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE COSTS (SEE EXHIB	241,694	568,538	4.05
4.06	5.04	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEES	0	1,023,297	4.06
4.07	5.04	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	5,577	4.07
4.08	5.04	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	25,075	4.08
4.09	5.04	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIO	0	513,397	4.09
4.10	5.04	OTHER ADMINISTRATIVE AND GEN	HIIM ALLOCATION	0	227,664	4.10
4.11	5.04	OTHER ADMINISTRATIVE AND GEN	PASI LIEN UNIT COLLECTION FE	0	20,367	4.11
4.12	5.04	OTHER ADMINISTRATIVE AND GEN	PPSI FEES	0	22,086	4.12
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,140,339	3,037,187	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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B	CHS, INC.	100.00	CHS, INC.	100.00	6.00
7.00			0.00		0.00	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:					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: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-1 Date/Time Prepared: 2/28/2019 4:45 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	125,329	11	1.00
2.00	6,924	14	2.00
3.00	1,204	14	3.00
4.00	-59,807	0	4.00
4.01	-16,154	0	4.01
4.02	16,968	14	4.02
4.03	107,192	14	4.03
4.04	1,085,803	0	4.04
4.05	-326,844	0	4.05
4.06	-1,023,297	0	4.06
4.07	-5,577	0	4.07
4.08	-25,075	0	4.08
4.09	-513,397	0	4.09
4.10	-227,664	0	4.10
4.11	-20,367	0	4.11
4.12	-22,086	0	4.12
5.00	-896,848		5.00

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

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

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

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

6.00	HOSPITAL MANAGE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 2/28/2019 4:45 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	17,192	17,192	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	36,438	0	36,438	211,500	292	2.00
3.00	30.00	ADULTS & PEDIATRICS	801,969	801,969	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	25,921	25,921	0	0	0	4.00
5.00	91.00	EMERGENCY	205,196	205,196	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,086,716	1,050,278	36,438		292	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	29,691	1,485	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			29,691	1,485	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	17,192		1.00
2.00	13.00	NURSING ADMINISTRATION	0	29,691	6,747	6,747		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	801,969		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	25,921		4.00
5.00	91.00	EMERGENCY	0	0	0	205,196		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	29,691	6,747	1,057,025		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	WELLS CRC COSTS-BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,513,703	1,513,703				1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	0	0	0			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,665,721			2,665,721		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,527,952	0	0	17,935	2,545,887	4.00
5.01	01160	COMMUNICATIONS	512,950	7,599	0	11,513	9,913	5.01
5.02	00540	ADMITTING	509,458	10,073	0	15,261	85,566	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	1,047,502	14,836	0	22,477	13,306	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	5,252,645	125,067	0	198,452	219,891	5.04
7.00	00700	OPERATION OF PLANT	2,304,734	87,735	0	132,924	70,237	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	143,167	1,480	0	34,235	0	8.00
9.00	00900	HOUSEKEEPING	370,986	6,250	0	9,470	47,446	9.00
10.00	01000	DIETARY	320,463	61,401	0	93,026	32,725	10.00
11.00	01100	CAFETERIA	421,073	0	0	41,194	44,647	11.00
13.00	01300	NURSING ADMINISTRATION	1,527,261	3,083	0	4,671	254,551	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	644,705	76,129	0	115,339	28,417	14.00
15.00	01500	PHARMACY	720,897	0	0	0	99,859	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	585,174	18,096	0	27,416	57,533	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,726,304	128,559	0	194,774	278,749	30.00
31.00	03100	INTENSIVE CARE UNIT	619,567	22,651	0	34,317	91,561	31.00
43.00	04300	NURSERY	586,520	3,769	0	5,710	81,918	43.00
44.00	04400	SKILLED NURSING FACILITY	777,006	45,987	0	69,673	124,868	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,384,688	120,990	0	183,308	204,935	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	189,728	4,439	0	6,726	26,499	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,076,492	84,229	0	127,611	177,525	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	144,972	5,487	0	8,314	12,399	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,649,346	34,881	0	52,847	160,126	60.00
65.00	06500	RESPIRATORY THERAPY	369,414	40,916	0	61,990	62,632	65.00
66.00	06600	PHYSICAL THERAPY	904,721	37,972	0	57,530	155,189	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	52,634	0	0	15,133	9,314	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	140,087	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	321,198	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,062,153	11,291	0	34,212	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	129,225	2,674	0	4,052	21,158	76.01
76.03	03953	WOUND CARE	64,728	0	0	0	9,683	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	66,057	8,277	0	12,540	9,843	90.00
91.00	09100	EMERGENCY	1,033,067	36,669	0	55,556	154,220	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,366,298	1,000,540	0	1,648,206	2,544,710	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,331	7,113	0	10,777	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	461,905	0	890,465	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	27,290	0	41,346	0	194.00
194.01	07955	MARKETING	0	16,855	0	25,536	0	194.01
194.02	07952	SENIOR CIRCLE	8,249	0	0	0	1,177	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	49,391	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	33,384,878	1,513,703	0	2,665,721	2,545,887	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	COMMUNICATIONS	Subtotal	ADMITTING	Subtotal	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5A.01	5.02	5A.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS	541,975					5.01
5.02	00540	ADMITTING	8,845	629,203	629,203			5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	6,433	1,104,554	21,217	1,125,771	1,125,771	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	41,814	5,837,869	112,137	5,950,006	207,636	5.04
7.00	00700	OPERATION OF PLANT	9,649	2,605,279	50,045	2,655,324	92,665	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	804	179,686	3,452	183,138	6,391	8.00
9.00	00900	HOUSEKEEPING	1,608	435,760	8,371	444,131	15,499	9.00
10.00	01000	DIETARY	7,237	514,852	9,890	524,742	18,312	10.00
11.00	01100	CAFETERIA	0	506,914	9,737	516,651	18,030	11.00
13.00	01300	NURSING ADMINISTRATION	2,412	1,791,978	34,422	1,826,400	63,738	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,021	868,611	16,685	885,296	30,895	14.00
15.00	01500	PHARMACY	8,845	829,601	15,936	845,537	29,508	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,103	708,322	13,606	721,928	25,194	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,082	2,344,468	45,035	2,389,503	83,389	30.00
31.00	03100	INTENSIVE CARE UNIT	4,021	772,117	14,832	786,949	27,463	31.00
43.00	04300	NURSERY	804	678,721	13,038	691,759	24,141	43.00
44.00	04400	SKILLED NURSING FACILITY	8,041	1,025,575	19,700	1,045,275	36,478	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,340	1,921,261	36,906	1,958,167	68,336	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,608	229,000	4,399	233,399	8,145	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,886	1,482,743	28,482	1,511,225	52,739	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	1,608	172,780	3,319	176,099	6,146	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	15,278	1,912,478	36,737	1,949,215	68,024	60.00
65.00	06500	RESPIRATORY THERAPY	2,412	537,364	10,322	547,686	19,113	65.00
66.00	06600	PHYSICAL THERAPY	4,021	1,159,433	22,272	1,181,705	41,239	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	4,825	81,906	1,573	83,479	2,913	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	140,087	2,691	142,778	4,983	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	321,198	6,170	327,368	11,424	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,107,656	21,277	1,128,933	39,398	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	157,109	3,018	160,127	5,588	76.01
76.03	03953	WOUND CARE	0	74,411	1,429	75,840	2,647	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,021	100,738	1,935	102,673	3,583	90.00
91.00	09100	EMERGENCY	13,670	1,293,182	24,841	1,318,023	45,996	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	232,388	31,524,856	593,474	31,489,127	1,059,613	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,216	31,437	604	32,041	1,118	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	306,371	1,658,741	31,863	1,690,604	58,999	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	68,636	1,318	69,954	2,441	194.00
194.01	07955	MARKETING	0	42,391	814	43,205	1,508	194.01
194.02	07952	SENIOR CIRCLE	0	9,426	181	9,607	335	194.02
194.03	07953	BUSINESS HEALTH	0	49,391	949	50,340	1,757	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	541,975	33,384,878	629,203	33,384,878	1,125,771	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.03	5.04	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	6,157,642	6,157,642				5.04
7.00	00700	OPERATION OF PLANT	2,747,989	621,489	3,369,478			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	189,529	42,863	50,881	283,273		8.00
9.00	00900	HOUSEKEEPING	459,630	103,949	14,074	0	577,653	9.00
10.00	01000	DIETARY	543,054	122,815	138,256	0	24,168	10.00
11.00	01100	CAFETERIA	534,681	120,922	61,223	0	10,702	11.00
13.00	01300	NURSING ADMINISTRATION	1,890,138	427,468	6,941	0	1,213	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	916,191	207,203	171,419	0	29,965	14.00
15.00	01500	PHARMACY	875,045	197,898	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	747,122	168,967	40,746	0	7,123	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,472,892	559,262	289,475	129,070	50,602	30.00
31.00	03100	INTENSIVE CARE UNIT	814,412	184,185	51,002	11,666	8,916	31.00
43.00	04300	NURSERY	715,900	161,906	8,486	0	1,483	43.00
44.00	04400	SKILLED NURSING FACILITY	1,081,753	244,646	103,549	0	18,101	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,026,503	458,308	272,434	60,866	47,623	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	241,544	54,627	9,996	0	1,747	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,563,964	353,701	189,657	29,917	33,153	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	182,245	41,216	12,356	0	2,160	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,017,239	456,213	78,542	0	13,730	60.00
65.00	06500	RESPIRATORY THERAPY	566,799	128,186	92,130	1,261	16,105	65.00
66.00	06600	PHYSICAL THERAPY	1,222,944	276,577	85,501	2,159	14,946	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	86,392	19,538	22,490	0	3,931	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	147,761	33,417	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	338,792	76,620	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,168,331	264,226	50,846	0	8,888	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	165,715	37,478	6,022	0	1,053	76.01
76.03	03953	WOUND CARE	78,487	17,750	0	4,470	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	106,256	24,031	18,638	0	3,258	90.00
91.00	09100	EMERGENCY	1,364,019	308,482	82,568	43,864	14,434	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,422,969	5,713,943	1,857,232	283,273	313,301	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,159	7,499	16,017	0	2,800	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,749,603	395,685	1,323,422	0	231,344	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	72,395	16,373	61,449	0	10,742	194.00
194.01	07955	MARKETING	44,713	10,112	37,952	0	6,634	194.01
194.02	07952	SENIOR CIRCLE	9,942	2,248	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	52,097	11,782	73,406	0	12,832	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	33,384,878	6,157,642	3,369,478	283,273	577,653	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	828,293					10.00
11.00	01100	CAFETERIA	0	727,528				11.00
13.00	01300	NURSING ADMINISTRATION	0	67,564	2,393,324			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,744	0	1,342,522		14.00
15.00	01500	PHARMACY	0	26,205	0	26,135	1,125,283	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,573	0	1,078	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	433,595	115,354	968,164	65,561	0	30.00
31.00	03100	INTENSIVE CARE UNIT	42,103	29,702	217,999	10,608	0	31.00
43.00	04300	NURSERY	0	25,212	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	352,595	55,173	248,572	9,094	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	71,276	445,938	72,755	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,159	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	63,203	58,471	27,808	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	3,713	0	28,647	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	73,090	32,846	209,455	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,061	12,428	6,859	0	65.00
66.00	06600	PHYSICAL THERAPY	0	52,367	0	6,540	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	3,324	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,732	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	263,424	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	541,428	1,125,283	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	6,864	0	3,691	0	76.01
76.03	03953	WOUND CARE	0	3,756	27,412	4,963	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,813	0	5,461	0	90.00
91.00	09100	EMERGENCY	0	50,943	381,494	45,033	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	828,293	727,096	2,393,324	1,337,272	1,125,283	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	5,250	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	432	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	828,293	727,528	2,393,324	1,342,522	1,125,283	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	994,609					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,411	5,135,386	0	5,135,386		30.00
31.00	03100	INTENSIVE CARE UNIT	11,095	1,381,688	0	1,381,688		31.00
43.00	04300	NURSERY	8,100	921,087	0	921,087		43.00
44.00	04400	SKILLED NURSING FACILITY	18,454	2,131,937	0	2,131,937		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	189,159	3,644,862	0	3,644,862		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,620	318,693	0	318,693		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	165,469	2,485,343	0	2,485,343		54.00
54.01	03630	ULTRA SOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	6,913	277,250	0	277,250		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	237,724	3,118,839	0	3,118,839		60.00
65.00	06500	RESPIRATORY THERAPY	16,700	862,529	0	862,529		65.00
66.00	06600	PHYSICAL THERAPY	40,104	1,701,138	0	1,701,138		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	17,377	153,052	0	153,052		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,780	226,690	0	226,690		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,576	704,412	0	704,412		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,473	3,231,475	0	3,231,475		73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0		76.00
76.01	03951	SLEEP LAB	3,736	224,559	0	224,559		76.01
76.03	03953	WOUND CARE	1,930	138,768	0	138,768		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,046	161,503	0	161,503		90.00
91.00	09100	EMERGENCY	86,942	2,377,779	0	2,377,779		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	994,609	29,196,990	0	29,196,990		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	64,725	0	64,725		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,700,054	0	3,700,054		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	160,959	0	160,959		194.00
194.01	07955	MARKETING	0	99,411	0	99,411		194.01
194.02	07952	SENIOR CIRCLE	0	12,622	0	12,622		194.02
194.03	07953	BUSINESS HEALTH	0	150,117	0	150,117		194.03
194.04	07954	VACANT SPACE	0	0	0	0		194.04
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)	994,609	33,384,878	0	33,384,878		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	WELLS CRC COSTS-BLDG & FIXT	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	17,935	17,935	4.00
5.01	01160	COMMUNICATIONS	0	7,599	0	11,513	19,112	5.01
5.02	00540	ADMITTING	0	10,073	0	15,261	25,334	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	14,836	0	22,477	37,313	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	125,067	0	198,452	323,519	5.04
7.00	00700	OPERATION OF PLANT	0	87,735	0	132,924	220,659	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,480	0	34,235	35,715	8.00
9.00	00900	HOUSEKEEPING	0	6,250	0	9,470	15,720	9.00
10.00	01000	DIETARY	0	61,401	0	93,026	154,427	10.00
11.00	01100	CAFETERIA	0	0	0	41,194	41,194	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,083	0	4,671	7,754	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	76,129	0	115,339	191,468	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,096	0	27,416	45,512	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	128,559	0	194,774	323,333	30.00
31.00	03100	INTENSIVE CARE UNIT	0	22,651	0	34,317	56,968	31.00
43.00	04300	NURSERY	0	3,769	0	5,710	9,479	43.00
44.00	04400	SKILLED NURSING FACILITY	0	45,987	0	69,673	115,660	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	120,990	0	183,308	304,298	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,439	0	6,726	11,165	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84,229	0	127,611	211,840	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	5,487	0	8,314	13,801	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	34,881	0	52,847	87,728	60.00
65.00	06500	RESPIRATORY THERAPY	0	40,916	0	61,990	102,906	65.00
66.00	06600	PHYSICAL THERAPY	0	37,972	0	57,530	95,502	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	15,133	15,133	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	11,291	0	34,212	45,503	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	2,674	0	4,052	6,726	76.01
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	8,277	0	12,540	20,817	90.00
91.00	09100	EMERGENCY	0	36,669	0	55,556	92,225	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,000,540	0	1,648,206	2,648,746	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,113	0	10,777	17,890	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	461,905	0	890,465	1,352,370	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	27,290	0	41,346	68,636	194.00
194.01	07955	MARKETING	0	16,855	0	25,536	42,391	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	49,391	49,391	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,513,703	0	2,665,721	4,179,424	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			4.00	5.01	5.02	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	17,935					4.00
5.01	01160	COMMUNICATIONS	70	19,182				5.01
5.02	00540	ADMITTING	603	313	26,250			5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	94	228	885	38,520		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	1,549	1,480	4,688	7,105	338,341	5.04
7.00	00700	OPERATION OF PLANT	495	342	2,087	3,170	34,137	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	28	144	219	2,355	8.00
9.00	00900	HOUSEKEEPING	334	57	349	530	5,712	9.00
10.00	01000	DIETARY	230	256	412	627	6,749	10.00
11.00	01100	CAFETERIA	314	0	406	617	6,644	11.00
13.00	01300	NURSING ADMINISTRATION	1,793	85	1,435	2,181	23,489	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	200	142	696	1,057	11,386	14.00
15.00	01500	PHARMACY	703	313	665	1,010	10,874	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	405	711	567	862	9,284	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,969	569	1,878	2,853	30,731	30.00
31.00	03100	INTENSIVE CARE UNIT	645	142	618	940	10,121	31.00
43.00	04300	NURSERY	577	28	544	826	8,896	43.00
44.00	04400	SKILLED NURSING FACILITY	879	285	821	1,248	13,443	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,443	968	1,539	2,338	25,183	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	187	57	183	279	3,002	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,250	598	1,188	1,804	19,435	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	87	57	138	210	2,265	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,128	541	1,532	2,327	25,068	60.00
65.00	06500	RESPIRATORY THERAPY	441	85	430	654	7,044	65.00
66.00	06600	PHYSICAL THERAPY	1,093	142	929	1,411	15,198	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	66	171	66	100	1,074	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	112	170	1,836	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	257	391	4,210	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	887	1,348	14,519	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	149	0	126	191	2,059	76.01
76.03	03953	WOUND CARE	68	0	60	91	975	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	69	142	81	123	1,320	90.00
91.00	09100	EMERGENCY	1,086	484	1,036	1,574	16,951	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,927	8,224	24,759	36,256	313,960	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	114	25	38	412	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,844	1,329	2,019	21,742	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	55	84	900	194.00
194.01	07955	MARKETING	0	0	34	52	556	194.01
194.02	07952	SENIOR CIRCLE	8	0	8	11	124	194.02
194.03	07953	BUSINESS HEALTH	0	0	40	60	647	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,935	19,182	26,250	38,520	338,341	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	260,890					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,940	42,401				8.00
9.00	00900	HOUSEKEEPING	1,090	0	23,792			9.00
10.00	01000	DIETARY	10,705	0	995	174,401		10.00
11.00	01100	CAFETERIA	4,740	0	441	0	54,356	11.00
13.00	01300	NURSING ADMINISTRATION	537	0	50	0	5,048	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,273	0	1,234	0	1,326	14.00
15.00	01500	PHARMACY	0	0	0	0	1,958	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,155	0	293	0	2,209	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,413	19,319	2,084	91,295	8,619	30.00
31.00	03100	INTENSIVE CARE UNIT	3,949	1,746	367	8,865	2,219	31.00
43.00	04300	NURSERY	657	0	61	0	1,884	43.00
44.00	04400	SKILLED NURSING FACILITY	8,018	0	746	74,241	4,122	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,094	9,111	1,961	0	5,325	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	774	0	72	0	610	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,685	4,478	1,366	0	4,722	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	957	0	89	0	277	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	6,081	0	565	0	5,461	60.00
65.00	06500	RESPIRATORY THERAPY	7,133	189	663	0	1,648	65.00
66.00	06600	PHYSICAL THERAPY	6,620	323	616	0	3,913	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	1,741	0	162	0	248	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	3,937	0	366	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	466	0	43	0	513	76.01
76.03	03953	WOUND CARE	0	669	0	0	281	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,443	0	134	0	135	90.00
91.00	09100	EMERGENCY	6,393	6,566	594	0	3,806	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	143,801	42,401	12,902	174,401	54,324	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,240	0	115	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	102,468	0	9,531	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	4,758	0	442	0	0	194.00
194.01	07955	MARKETING	2,939	0	273	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	32	194.02
194.03	07953	BUSINESS HEALTH	5,684	0	529	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	260,890	42,401	23,792	174,401	54,356	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	42,372					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	220,782				14.00
15.00	01500	PHARMACY	0	4,298	19,821			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	177	0	63,175		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,142	10,782	0	3,263	536,250	30.00
31.00	03100	INTENSIVE CARE UNIT	3,859	1,745	0	704	92,888	31.00
43.00	04300	NURSERY	0	0	0	514	23,466	43.00
44.00	04400	SKILLED NURSING FACILITY	4,401	1,496	0	1,171	226,531	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,895	11,965	0	12,007	405,127	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	166	16,495	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,035	4,573	0	10,503	277,477	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	4,711	0	439	23,031	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	581	34,446	0	15,132	180,590	60.00
65.00	06500	RESPIRATORY THERAPY	220	1,128	0	1,060	123,601	65.00
66.00	06600	PHYSICAL THERAPY	0	1,076	0	2,546	129,369	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	1,103	19,864	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,436	0	2,335	5,889	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	43,321	0	1,624	49,803	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	89,038	19,821	4,600	180,019	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	607	0	237	11,117	76.01
76.03	03953	WOUND CARE	485	816	0	122	3,567	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	898	0	130	25,292	90.00
91.00	09100	EMERGENCY	6,754	7,406	0	5,519	150,394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,372	219,919	19,821	63,175	2,480,770	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	863	0	0	20,697	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,500,303	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	74,875	194.00
194.01	07955	MARKETING	0	0	0	0	46,245	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	183	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	56,351	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	42,372	220,782	19,821	63,175	4,179,424	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	01160	COMMUNICATIONS			5.01
5.02	00540	ADMITTING			5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL			5.04
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	536,250	30.00
31.00	03100	INTENSIVE CARE UNIT	0	92,888	31.00
43.00	04300	NURSERY	0	23,466	43.00
44.00	04400	SKILLED NURSING FACILITY	0	226,531	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	405,127	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	16,495	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	277,477	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	23,031	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	180,590	60.00
65.00	06500	RESPIRATORY THERAPY	0	123,601	65.00
66.00	06600	PHYSICAL THERAPY	0	129,369	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	19,864	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,889	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	49,803	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	180,019	73.00
76.00	03950	OTHER ANCILLARY	0	0	76.00
76.01	03951	SLEEP LAB	0	11,117	76.01
76.03	03953	WOUND CARE	0	3,567	76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	25,292	90.00
91.00	09100	EMERGENCY	0	150,394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,480,770	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,697	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,500,303	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	74,875	194.00
194.01	07955	MARKETING	0	46,245	194.01
194.02	07952	SENIOR CIRCLE	0	183	194.02
194.03	07953	BUSINESS HEALTH	0	56,351	194.03
194.04	07954	VACANT SPACE	0	0	194.04
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,179,424	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	WELLS CRC COSTS-BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NONPATIENT PHONES)	
			1.00	1.01	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	196,409					1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	0	119,997				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			228,300			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,536	1,536	13,441,470		4.00
5.01	01160	COMMUNICATIONS	986	0	986	52,337	674	5.01
5.02	00540	ADMITTING	1,307	0	1,307	451,761	11	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	1,925	0	1,925	70,251	8	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	16,228	768	16,996	1,160,958	52	5.04
7.00	00700	OPERATION OF PLANT	11,384	0	11,384	370,831	12	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	192	2,740	2,932	0	1	8.00
9.00	00900	HOUSEKEEPING	811	0	811	250,499	2	9.00
10.00	01000	DIETARY	7,967	0	7,967	172,776	9	10.00
11.00	01100	CAFETERIA	0	3,528	3,528	235,721	0	11.00
13.00	01300	NURSING ADMINISTRATION	400	0	400	1,343,952	3	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,878	0	9,878	150,032	5	14.00
15.00	01500	PHARMACY	0	0	0	527,223	11	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,348	0	2,348	303,755	25	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,681	0	16,681	1,471,682	20	30.00
31.00	03100	INTENSIVE CARE UNIT	2,939	0	2,939	483,412	5	31.00
43.00	04300	NURSERY	489	0	489	432,504	1	43.00
44.00	04400	SKILLED NURSING FACILITY	5,967	0	5,967	659,267	10	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,699	0	15,699	1,081,994	34	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	576	0	576	139,907	2	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,929	0	10,929	937,279	21	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	712	0	712	65,464	2	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,526	0	4,526	845,417	19	60.00
65.00	06500	RESPIRATORY THERAPY	5,309	0	5,309	330,679	3	65.00
66.00	06600	PHYSICAL THERAPY	4,927	0	4,927	819,348	5	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	1,296	1,296	49,173	6	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	1,465	1,465	2,930	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	347	0	347	111,710	0	76.01
76.03	03953	WOUND CARE	0	0	0	51,121	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,074	0	1,074	51,967	5	90.00
91.00	09100	EMERGENCY	4,758	0	4,758	814,235	17	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	129,824	11,333	141,157	13,435,255	289	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	923	0	923	0	4	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,934	16,328	76,262	0	381	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	3,541	0	3,541	0	0	194.00
194.01	07955	MARKETING	2,187	0	2,187	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	6,215	0	194.02
194.03	07953	BUSINESS HEALTH	0	4,230	4,230	0	0	194.03
194.04	07954	VACANT SPACE	0	88,106	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,513,703	0	2,665,721	2,545,887	541,975	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.706892	0.000000	11.676395	0.189405	804.117211	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				17,935	19,182	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/28/2019 4:45 pm

		CAPITAL RELATED COSTS					
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	WELLS CRC COSTS-BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NONPATIENT PHONES)	
		1.00	1.01	2.00	4.00	5.01	
205.00	Unit cost multiplier (Wkst. B, Part II)				0.001334	28.459941	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: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	Reconciliation	ADMITTING (ACCUM. COST)	Reconciliation	CASHIERING/ACCOUNTS RECEIVABLE (ACCUM. COST)	Reconciliation	
			5A.02	5.02	5A.03	5.03	5A.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING	-629,203	32,755,675				5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	1,104,554	-1,125,771	32,259,107		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	5,837,869	0	5,950,006	-6,157,642	5.04
7.00	00700	OPERATION OF PLANT	0	2,605,279	0	2,655,324	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	179,686	0	183,138	0	8.00
9.00	00900	HOUSEKEEPING	0	435,760	0	444,131	0	9.00
10.00	01000	DIETARY	0	514,852	0	524,742	0	10.00
11.00	01100	CAFETERIA	0	506,914	0	516,651	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,791,978	0	1,826,400	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	868,611	0	885,296	0	14.00
15.00	01500	PHARMACY	0	829,601	0	845,537	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	708,322	0	721,928	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,344,468	0	2,389,503	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	772,117	0	786,949	0	31.00
43.00	04300	NURSERY	0	678,721	0	691,759	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,025,575	0	1,045,275	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,921,261	0	1,958,167	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	229,000	0	233,399	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,482,743	0	1,511,225	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	172,780	0	176,099	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,912,478	0	1,949,215	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	537,364	0	547,686	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,159,433	0	1,181,705	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	81,906	0	83,479	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	140,087	0	142,778	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	321,198	0	327,368	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,107,656	0	1,128,933	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	157,109	0	160,127	0	76.01
76.03	03953	WOUND CARE	0	74,411	0	75,840	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	100,738	0	102,673	0	90.00
91.00	09100	EMERGENCY	0	1,293,182	0	1,318,023	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-629,203	30,895,653	-1,125,771	30,363,356	-6,157,642	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	31,437	0	32,041	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,658,741	0	1,690,604	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	68,636	0	69,954	0	194.00
194.01	07955	MARKETING	0	42,391	0	43,205	0	194.01
194.02	07952	SENIOR CIRCLE	0	9,426	0	9,607	0	194.02
194.03	07953	BUSINESS HEALTH	0	49,391	0	50,340	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		629,203		1,125,771		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.019209		0.034898		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		26,250		38,520		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000801		0.001194		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0075	Period: From 10/01/2017 To 09/30/2018	Worksheet B-1 Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	Reconciliation	ADMITTING (ACCUM. COST)	Reconciliation	CASHIERING/ACCOUNTS RECEIVABLE (ACCUM. COST)	Reconciliation	
			5A.02	5.02	5A.03	5.03	5A.04	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.04	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	27,227,236					5.04
7.00	00700	OPERATION OF PLANT	2,747,989	194,166				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	189,529	2,932	238,398			8.00
9.00	00900	HOUSEKEEPING	459,630	811	0	190,423		9.00
10.00	01000	DIETARY	543,054	7,967	0	7,967	28,939	10.00
11.00	01100	CAFETERIA	534,681	3,528	0	3,528	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,890,138	400	0	400	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	916,191	9,878	0	9,878	0	14.00
15.00	01500	PHARMACY	875,045	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	747,122	2,348	0	2,348	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,472,892	16,681	108,623	16,681	15,149	30.00
31.00	03100	INTENSIVE CARE UNIT	814,412	2,939	9,818	2,939	1,471	31.00
43.00	04300	NURSERY	715,900	489	0	489	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,081,753	5,967	0	5,967	12,319	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,026,503	15,699	51,224	15,699	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	241,544	576	0	576	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,563,964	10,929	25,178	10,929	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	182,245	712	0	712	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,017,239	4,526	0	4,526	0	60.00
65.00	06500	RESPIRATORY THERAPY	566,799	5,309	1,061	5,309	0	65.00
66.00	06600	PHYSICAL THERAPY	1,222,944	4,927	1,817	4,927	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	86,392	1,296	0	1,296	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	147,761	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	338,792	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,168,331	2,930	0	2,930	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	165,715	347	0	347	0	76.01
76.03	03953	WOUND CARE	78,487	0	3,762	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	106,256	1,074	0	1,074	0	90.00
91.00	09100	EMERGENCY	1,364,019	4,758	36,915	4,758	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,265,327	107,023	238,398	103,280	28,939	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,159	923	0	923	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,749,603	76,262	0	76,262	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	72,395	3,541	0	3,541	0	194.00
194.01	07955	MARKETING	44,713	2,187	0	2,187	0	194.01
194.02	07952	SENIOR CIRCLE	9,942	0	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	52,097	4,230	0	4,230	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,157,642	3,369,478	283,273	577,653	828,293	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.226157	17.353594	1.188236	3.033525	28.622033	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	338,341	260,890	42,401	23,792	174,401	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.012427	1.343644	0.177858	0.124943	6.026504	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.04	7.00	8.00	9.00	10.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES IN NURSING ARE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (% COSTED REQUI)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	16,852					11.00
13.00	01300	NURSING ADMINISTRATION	1,565	3,208,939				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	411	0	2,641,974			14.00
15.00	01500	PHARMACY	607	0	51,431	1,116,918		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	685	0	2,121	0	194,268,970	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,672	1,298,103	129,019	0	10,041,229	30.00
31.00	03100	INTENSIVE CARE UNIT	688	292,290	20,876	0	2,167,088	31.00
43.00	04300	NURSERY	584	0	0	0	1,581,948	43.00
44.00	04400	SKILLED NURSING FACILITY	1,278	333,282	17,896	0	3,604,204	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,651	597,908	143,175	0	36,945,128	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	189	0	0	0	511,732	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,464	78,397	54,724	0	32,318,211	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	86	0	56,375	0	1,350,138	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,693	44,039	412,191	0	46,440,070	60.00
65.00	06500	RESPIRATORY THERAPY	511	16,663	13,498	0	3,261,667	65.00
66.00	06600	PHYSICAL THERAPY	1,213	0	12,871	0	7,832,822	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	77	0	0	0	3,393,909	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	17,183	0	7,183,504	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	518,397	0	4,995,393	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,065,487	1,116,918	14,154,830	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	159	0	7,264	0	729,676	76.01
76.03	03953	WOUND CARE	87	36,754	9,766	0	376,905	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	42	0	10,747	0	399,656	90.00
91.00	09100	EMERGENCY	1,180	511,503	88,622	0	16,980,860	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,842	3,208,939	2,631,643	1,116,918	194,268,970	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	10,331	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	10	0	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	727,528	2,393,324	1,342,522	1,125,283	994,609	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.171612	0.745830	0.508151	1.007489	0.005120	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	54,356	42,372	220,782	19,821	63,175	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.225493	0.013204	0.083567	0.017746	0.000325	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/28/2019 4:45 pm

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES IN NURSING ARE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (% COSTED REQUI)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
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: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I | Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,135,386		5,135,386	0	5,135,386	30.00
31.00	03100	INTENSIVE CARE UNIT	1,381,688		1,381,688	0	1,381,688	31.00
43.00	04300	NURSERY	921,087		921,087	0	921,087	43.00
44.00	04400	SKILLED NURSING FACILITY	2,131,937		2,131,937	0	2,131,937	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,644,862		3,644,862	0	3,644,862	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	318,693		318,693	0	318,693	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,485,343		2,485,343	0	2,485,343	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	277,250		277,250	0	277,250	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,118,839		3,118,839	0	3,118,839	60.00
65.00	06500	RESPIRATORY THERAPY	862,529	0	862,529	0	862,529	65.00
66.00	06600	PHYSICAL THERAPY	1,701,138	0	1,701,138	0	1,701,138	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	153,052		153,052	0	153,052	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	226,690		226,690	0	226,690	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	704,412		704,412	0	704,412	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,231,475		3,231,475	0	3,231,475	73.00
76.00	03950	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	224,559		224,559	0	224,559	76.01
76.03	03953	WOUND CARE	138,768		138,768	0	138,768	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	161,503		161,503	0	161,503	90.00
91.00	09100	EMERGENCY	2,377,779		2,377,779	0	2,377,779	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	956,838		956,838		956,838	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	30,153,828	0	30,153,828	0	30,153,828	200.00
201.00		Less Observation Beds	956,838		956,838		956,838	201.00
202.00		Total (see instructions)	29,196,990	0	29,196,990	0	29,196,990	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/28/2019 4:45 pm

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	7,672,213		7,672,213			30.00
31.00	03100	INTENSIVE CARE UNIT	2,167,088		2,167,088			31.00
43.00	04300	NURSERY	1,581,948		1,581,948			43.00
44.00	04400	SKILLED NURSING FACILITY	3,604,204		3,604,204			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,187,252	28,757,876	36,945,128	0.098656	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	374,885	136,847	511,732	0.622773	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,342,952	27,975,259	32,318,211	0.076902	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	73,798	1,276,340	1,350,138	0.205349	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	9,517,462	36,922,608	46,440,070	0.067158	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,965,712	295,955	3,261,667	0.264444	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,076,764	3,756,058	7,832,822	0.217181	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,650,874	1,743,035	3,393,909	0.045096	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,488,864	3,694,640	7,183,504	0.031557	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,408,754	1,586,639	4,995,393	0.141012	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,553,909	8,600,921	14,154,830	0.228295	0.000000	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	729,676	729,676	0.307752	0.000000	76.01
76.03	03953	WOUND CARE	4,766	372,139	376,905	0.368178	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	31,424	368,232	399,656	0.404105	0.000000	90.00
91.00	09100	EMERGENCY	3,121,544	13,859,316	16,980,860	0.140027	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	257,780	2,111,236	2,369,016	0.403897	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	62,082,193	132,186,777	194,268,970			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	62,082,193	132,186,777	194,268,970			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I | Date/Time Prepared: 2/28/2019 4:45 pm

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
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.098656	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.622773	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076902	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.205349	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.067158	60.00
65.00	06500	RESPIRATORY THERAPY	0.264444	65.00
66.00	06600	PHYSICAL THERAPY	0.217181	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045096	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.031557	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141012	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228295	73.00
76.00	03950	OTHER ANCILLARY	0.000000	76.00
76.01	03951	SLEEP LAB	0.307752	76.01
76.03	03953	WOUND CARE	0.368178	76.03
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.404105	90.00
91.00	09100	EMERGENCY	0.140027	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.403897	92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
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: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/28/2019 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,135,386		5,135,386	0	5,135,386	30.00
31.00	03100	INTENSIVE CARE UNIT	1,381,688		1,381,688	0	1,381,688	31.00
43.00	04300	NURSERY	921,087		921,087	0	921,087	43.00
44.00	04400	SKILLED NURSING FACILITY	2,131,937		2,131,937	0	2,131,937	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,644,862		3,644,862	0	3,644,862	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	318,693		318,693	0	318,693	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,485,343		2,485,343	0	2,485,343	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	277,250		277,250	0	277,250	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,118,839		3,118,839	0	3,118,839	60.00
65.00	06500	RESPIRATORY THERAPY	862,529	0	862,529	0	862,529	65.00
66.00	06600	PHYSICAL THERAPY	1,701,138	0	1,701,138	0	1,701,138	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	153,052		153,052	0	153,052	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	226,690		226,690	0	226,690	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	704,412		704,412	0	704,412	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,231,475		3,231,475	0	3,231,475	73.00
76.00	03950	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	224,559		224,559	0	224,559	76.01
76.03	03953	WOUND CARE	138,768		138,768	0	138,768	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	161,503		161,503	0	161,503	90.00
91.00	09100	EMERGENCY	2,377,779		2,377,779	0	2,377,779	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	956,838		956,838		956,838	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	30,153,828	0	30,153,828	0	30,153,828	200.00
201.00		Less Observation Beds	956,838		956,838		956,838	201.00
202.00		Total (see instructions)	29,196,990	0	29,196,990	0	29,196,990	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I | Date/Time Prepared: 2/28/2019 4:45 pm

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	7,672,213		7,672,213			30.00
31.00	03100	INTENSIVE CARE UNIT	2,167,088		2,167,088			31.00
43.00	04300	NURSERY	1,581,948		1,581,948			43.00
44.00	04400	SKILLED NURSING FACILITY	3,604,204		3,604,204			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,187,252	28,757,876	36,945,128	0.098656	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	374,885	136,847	511,732	0.622773	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,342,952	27,975,259	32,318,211	0.076902	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	73,798	1,276,340	1,350,138	0.205349	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	9,517,462	36,922,608	46,440,070	0.067158	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,965,712	295,955	3,261,667	0.264444	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,076,764	3,756,058	7,832,822	0.217181	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,650,874	1,743,035	3,393,909	0.045096	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,488,864	3,694,640	7,183,504	0.031557	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,408,754	1,586,639	4,995,393	0.141012	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,553,909	8,600,921	14,154,830	0.228295	0.000000	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	729,676	729,676	0.307752	0.000000	76.01
76.03	03953	WOUND CARE	4,766	372,139	376,905	0.368178	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	31,424	368,232	399,656	0.404105	0.000000	90.00
91.00	09100	EMERGENCY	3,121,544	13,859,316	16,980,860	0.140027	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	257,780	2,111,236	2,369,016	0.403897	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	62,082,193	132,186,777	194,268,970			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	62,082,193	132,186,777	194,268,970			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/28/2019 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	OTHER ANCILLARY	0.000000	76.00
76.01	03951	SLEEP LAB	0.000000	76.01
76.03	03953	WOUND CARE	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
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: 15-0075

Period: From 10/01/2017 To 09/30/2018

Worksheet D Part I

Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	536,250	0	536,250	4,621	116.05	30.00
31.00	INTENSIVE CARE UNIT	92,888		92,888	520	178.63	31.00
43.00	NURSERY	23,466		23,466	479	48.99	43.00
44.00	SKILLED NURSING FACILITY	226,531		226,531	3,137	72.21	44.00
200.00	Total (lines 30 through 199)	879,135		879,135	8,757		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	1,337	155,159	30.00
31.00	INTENSIVE CARE UNIT	222	39,656	31.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	1,405	101,455	44.00
200.00	Total (lines 30 through 199)	2,964	296,270	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part II Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	405,127	36,945,128	0.010966	2,418,096	26,517	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,495	511,732	0.032234	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	277,477	32,318,211	0.008586	1,576,144	13,533	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	23,031	1,350,138	0.017058	42,052	717	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	180,590	46,440,070	0.003889	3,338,798	12,985	60.00
65.00	06500	RESPIRATORY THERAPY	123,601	3,261,667	0.037895	1,032,098	39,111	65.00
66.00	06600	PHYSICAL THERAPY	129,369	7,832,822	0.016516	194,666	3,215	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	19,864	3,393,909	0.005853	670,202	3,923	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,889	7,183,504	0.000820	1,136,984	932	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,803	4,995,393	0.009970	1,625,336	16,205	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	180,019	14,154,830	0.012718	1,668,420	21,219	73.00
76.00	03950	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	11,117	729,676	0.015236	0	0	76.01
76.03	03953	WOUND CARE	3,567	376,905	0.009464	2,536	24	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	25,292	399,656	0.063284	3,477	220	90.00
91.00	09100	EMERGENCY	150,394	16,980,860	0.008857	1,217,510	10,783	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	99,916	2,369,016	0.042176	87,502	3,690	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,701,551	179,243,517		15,013,821	153,074	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part III Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	4,621	0.00	1,337	30.00
31.00	03100	INTENSIVE CARE UNIT		0	520	0.00	222	31.00
43.00	04300	NURSERY		0	479	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	3,137	0.00	1,405	44.00
200.00		Total (lines 30 through 199)		0	8,757		2,964	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
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/28/2019 4:45 pm

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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	36,945,128	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	511,732	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,318,211	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	1,350,138	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	46,440,070	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,261,667	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,832,822	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	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,393,909	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,183,504	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,995,393	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,154,830	0.000000	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	729,676	0.000000	76.01
76.03	03953	WOUND CARE	0	0	0	376,905	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	399,656	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	16,980,860	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,369,016	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	179,243,517		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	2,418,096	0	6,045,948	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,576,144	0	6,890,133	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	42,052	0	296,849	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	3,338,798	0	3,199,149	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,032,098	0	77,546	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	194,666	0	16,296	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	670,202	0	904,578	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,136,984	0	802,589	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,625,336	0	567,349	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,668,420	0	2,542,831	0	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	99,358	0	76.01
76.03	03953	WOUND CARE	0.000000	2,536	0	114,048	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	3,477	0	129,756	0	90.00
91.00	09100	EMERGENCY	0.000000	1,217,510	0	2,932,145	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	87,502	0	652,153	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		15,013,821	0	25,270,728	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.098656	6,045,948	0	0	596,469	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.622773	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076902	6,890,133	0	0	529,865	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.205349	296,849	0	0	60,958	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.067158	3,199,149	0	0	214,848	60.00
65.00	06500	RESPIRATORY THERAPY	0.264444	77,546	0	0	20,507	65.00
66.00	06600	PHYSICAL THERAPY	0.217181	16,296	0	0	3,539	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045096	904,578	0	0	40,793	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.031557	802,589	0	0	25,327	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141012	567,349	0	0	80,003	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228295	2,542,831	0	4,241	580,516	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.307752	99,358	0	0	30,578	76.01
76.03	03953	WOUND CARE	0.368178	114,048	0	0	41,990	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.404105	129,756	0	186	52,435	90.00
91.00	09100	EMERGENCY	0.140027	2,932,145	0	0	410,579	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.403897	652,153	0	0	263,403	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		25,270,728	0	4,427	2,951,810	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		25,270,728	0	4,427	2,951,810	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V | Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	968	73.00
76.00	03950	OTHER ANCILLARY	0	0	76.00
76.01	03951	SLEEP LAB	0	0	76.01
76.03	03953	WOUND CARE	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	75	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	1,043	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	1,043	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Skilled Nursing Facility | 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	36,945,128	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	511,732	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,318,211	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	1,350,138	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	46,440,070	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,261,667	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,832,822	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	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,393,909	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,183,504	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,995,393	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,154,830	0.000000	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	729,676	0.000000	76.01
76.03	03953	WOUND CARE	0	0	0	376,905	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	399,656	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	16,980,860	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,369,016	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	179,243,517		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Skilled Nursing Facility | 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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	24,202	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	189,841	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	360,058	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,639,130	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,262	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	228,490	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	531,889	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03953	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,980,872	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/28/2019 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.098656	0	63,840	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.622773	0	3,400	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076902	0	209,399	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.205349	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.067158	0	399,268	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.264444	0	8,292	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.217181	0	255,055	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045096	0	14,176	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.031557	0	12,289	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141012	0	132	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228295	0	107,756	0	0	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.307752	0	0	0	0	76.01
76.03	03953	WOUND CARE	0.368178	0	1,748	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.404105	0	2,350	0	0	90.00
91.00	09100	EMERGENCY	0.140027	0	200,488	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.403897	0	2,952	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	1,281,145	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	1,281,145	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/28/2019 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	6,298	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,117	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,103	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	26,814	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,193	0	65.00
66.00	06600	PHYSICAL THERAPY	55,393	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	639	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	388	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,600	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	76.00
76.01	03951	SLEEP LAB	0	0	76.01
76.03	03953	WOUND CARE	644	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	950	0	90.00
91.00	09100	EMERGENCY	28,074	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,192	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	165,424	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	165,424	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,621	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,621	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.	1,092	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,668	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)	1,337	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)	5,135,386	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)	5,135,386	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	3,867,930	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,867,930	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.327683	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)	1,449.75	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)	5,135,386	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)	1,111.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,485,821	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)	1,485,821	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,381,688	520	2,657.09	222	589,874	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,792,193	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,867,888	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)	194,815	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	153,074	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	347,889	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,519,999	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)	861	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,111.31	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	956,838	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0075	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/28/2019 4:45 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	536,250	5,135,386	0.104423	956,838	99,916	90.00
91.00	Nursing School cost	0	5,135,386	0.000000	956,838	0	91.00
92.00	Allied health cost	0	5,135,386	0.000000	956,838	0	92.00
93.00	All other Medical Education	0	5,135,386	0.000000	956,838	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,137	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,137	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.	2,159	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	978	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)	1,405	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)	2,131,937	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)	2,131,937	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	1,609,169	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,609,169	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.324868	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)	1,645.37	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)	2,131,937	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0075 Component CCN: 15-5373	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/28/2019 4:45 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,131,937	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	679.61	71.00
72.00	Program routine service cost (line 9 x line 71)	954,852	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	954,852	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	954,852	83.00
84.00	Program inpatient ancillary services (see instructions)	594,778	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	1,549,630	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0075 Component CCN: 15-5373	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/28/2019 4:45 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,808,836		30.00
31.00	03100	INTENSIVE CARE UNIT		1,059,094		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.098656	2,418,096	238,560	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.622773	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076902	1,576,144	121,209	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.205349	42,052	8,635	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.067158	3,338,798	224,227	60.00
65.00	06500	RESPIRATORY THERAPY	0.264444	1,032,098	272,932	65.00
66.00	06600	PHYSICAL THERAPY	0.217181	194,666	42,278	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045096	670,202	30,223	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.031557	1,136,984	35,880	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141012	1,625,336	229,192	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228295	1,668,420	380,892	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.307752	0	0	76.01
76.03	03953	WOUND CARE	0.368178	2,536	934	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.404105	3,477	1,405	90.00
91.00	09100	EMERGENCY	0.140027	1,217,510	170,484	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.403897	87,502	35,342	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		15,013,821	1,792,193	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)		15,013,821		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0075 Component CCN: 15-5373	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/28/2019 4:45 pm
	Title XVIII	Skilled Nursing Facility	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.098656	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.622773	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076902	24,202	1,861	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.205349	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.067158	189,841	12,749	60.00
65.00	06500	RESPIRATORY THERAPY	0.264444	360,058	95,215	65.00
66.00	06600	PHYSICAL THERAPY	0.217181	1,639,130	355,988	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045096	7,262	327	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.031557	228,490	7,210	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141012	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228295	531,889	121,428	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.307752	0	0	76.01
76.03	03953	WOUND CARE	0.368178	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.404105	0	0	90.00
91.00	09100	EMERGENCY	0.140027	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.403897	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,980,872	594,778	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,980,872		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/28/2019 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		90,880		30.00
31.00	03100	INTENSIVE CARE UNIT		33,681		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.098656	88,468	8,728	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.622773	3,056	1,903	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076902	26,213	2,016	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.205349	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.067158	78,538	5,274	60.00
65.00	06500	RESPIRATORY THERAPY	0.264444	30,223	7,992	65.00
66.00	06600	PHYSICAL THERAPY	0.217181	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045096	16,690	753	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.031557	31,427	992	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141012	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228295	47,647	10,878	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.307752	0	0	76.01
76.03	03953	WOUND CARE	0.368178	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.404105	0	0	90.00
91.00	09100	EMERGENCY	0.140027	25,071	3,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.403897	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		347,333	42,047	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)		347,333		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/28/2019 4:45 pm
	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)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,055,175	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)	15,700	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	1,613,088	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	59.64	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)	3.16	30.00
31.00	Percentage of Medicaid patient days (see instructions)	24.00	31.00
32.00	Sum of lines 30 and 31	27.16	32.00
33.00	Allowable disproportionate share percentage (see instructions)	11.62	33.00
34.00	Disproportionate share adjustment (see instructions)	88,753	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/28/2019 4:45 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000046132	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	312,161	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	312,161	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	312,161		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)	3,471,789		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)	3,471,789	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	250,878	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)	3,722,667	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	3,722,667	61.00
62.00	Deductibles billed to program beneficiaries	456,120	62.00
63.00	Coinsurance billed to program beneficiaries	4,020	63.00
64.00	Allowable bad debts (see instructions)	25,315	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	16,455	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,024	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	3,278,982	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)	24,716	70.93
70.94	HRR adjustment amount (see instructions)	-48,272	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E Part A Date/Time Prepared: 2/28/2019 4:45 pm

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)	2018	491,924	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)		3,747,350	71.00
71.01	Sequestration adjustment (see instructions)		74,947	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		3,537,552	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)		134,851	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		51,692	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	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		1.0080897677	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.9842	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		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: 15-0075

Period: From 10/01/2017 To 09/30/2018

Worksheet E Part A Exhibit 4
Date/Time Prepared: 2/28/2019 4:45 pm

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	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,055,175	0		3,055,175	3,055,175	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	15,700	0	0	15,700	15,700	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	1,613,088	0	0	1,613,088	1,613,088	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	0.1162	0.1162	0.1162	0.1162		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	88,753	0	0	88,753	88,753	11.00
11.01	Uncompensated care payments	36.00	312,161	0	0	312,161	312,161	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	3,471,789	0	0	3,471,789	3,471,789	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	3,471,789	0	0	3,471,789	3,471,789	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	250,878	0	0	250,878	250,878	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: 15-0075	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/28/2019 4:45 pm
	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	0	3,722,667	3,722,667	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	248,881	0	0	248,881	248,881	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	1,997	0	0	1,997	1,997	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	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	250,878	0	0	250,878	250,878	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	0.132143		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				491,924	491,924	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E Part B Date/Time Prepared: 2/28/2019 4:45 pm

		Title XVIII	Hospital	PPS	

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,043	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,951,810	2.00
3.00	OPPS payments	2,779,264	3.00
4.00	Outlier payment (see instructions)	2,399	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,043	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	4,427	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	4,427	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	4,427	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,384	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	1,043	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)	2,781,663	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	1,826	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	558,400	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,222,480	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,222,480	30.00
31.00	Primary payer payments	512	31.00
32.00	Subtotal (line 30 minus line 31)	2,221,968	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)	90,210	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	58,637	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	75,341	36.00
37.00	Subtotal (see instructions)	2,280,605	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS PS&R	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,280,605	40.00
40.01	Sequestration adjustment (see instructions)	45,612	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,176,533	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	58,460	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: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,537,552		2,176,533	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)		3,537,552		2,176,533	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		134,851		58,460	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,672,403		2,234,993	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I

Component CCN: 15-5373 | Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Skilled Nursing Facility | 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		537,034		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		537,034		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		1		0	6.02
7.00	Total Medicare program liability (see instructions)		537,033		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0075	Period: From 10/01/2017 To 09/30/2018	Worksheet E-1 Part II Date/Time Prepared: 2/28/2019 4:45 pm
	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: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-3 Part VI | Date/Time Prepared: 2/28/2019 4:45 pm

Title XVIII | Skilled Nursing Facility | PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	586,431	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	586,431	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	38,438	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	547,993	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	ROUNDING	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	547,993	15.00
15.01	Sequestration adjustment (see instructions)	10,960	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	537,034	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	-1	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G Date/Time Prepared: 2/28/2019 4:45 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-37,152	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	10,511,145	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,740,337	0	0	0	6.00
7.00	Inventory	1,082,453	0	0	0	7.00
8.00	Prepaid expenses	389,440	0	0	0	8.00
9.00	Other current assets	22,831	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,228,380	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,844,900	0	0	0	12.00
13.00	Land improvements	719,024	0	0	0	13.00
14.00	Accumulated depreciation	-496,970	0	0	0	14.00
15.00	Buildings	20,284,298	0	0	0	15.00
16.00	Accumulated depreciation	-10,353,489	0	0	0	16.00
17.00	Leasehold improvements	7,166,220	0	0	0	17.00
18.00	Accumulated depreciation	-3,682,210	0	0	0	18.00
19.00	Fixed equipment	3,900,057	0	0	0	19.00
20.00	Accumulated depreciation	-3,159,677	0	0	0	20.00
21.00	Automobiles and trucks	47,177	0	0	0	21.00
22.00	Accumulated depreciation	-35,940	0	0	0	22.00
23.00	Major movable equipment	12,817,393	0	0	0	23.00
24.00	Accumulated depreciation	-8,836,980	0	0	0	24.00
25.00	Minor equipment depreciable	3,115,006	0	0	0	25.00
26.00	Accumulated depreciation	-2,557,492	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)	22,771,317	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,960,509	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,960,509	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	34,960,206	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	926,450	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,079,752	0	0	0	38.00
39.00	Payroll taxes payable	-210	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	30,523,188	0	0	0	43.00
44.00	Other current liabilities	237,518	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	32,766,698	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,766,698	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	2,193,508				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	2,193,508	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	34,960,206	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-1 | Date/Time Prepared: 2/28/2019 4:45 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		1,628,688		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-606,532				2.00
3.00	Total (sum of line 1 and line 2)		1,022,156		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,022,156		0		11.00
12.00	PLUG TO RE	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,022,156		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	PLUG TO RE		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			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: 15-0075 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/28/2019 4:45 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	9,254,161		9,254,161	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	3,604,204		3,604,204	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)	12,858,365		12,858,365	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,167,088		2,167,088	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	2,167,088		2,167,088	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15,025,453		15,025,453	17.00
18.00	Ancillary services	43,641,741	115,852,244	159,493,985	18.00
19.00	Outpatient services	3,410,748	16,338,784	19,749,532	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	62,077,942	132,191,028	194,268,970	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		37,095,952		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)		37,095,952		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0075	Period: From 10/01/2017 To 09/30/2018	Worksheet G-3 Date/Time Prepared: 2/28/2019 4:45 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	194,268,970	1.00
2.00	Less contractual allowances and discounts on patients' accounts	158,324,595	2.00
3.00	Net patient revenues (line 1 minus line 2)	35,944,375	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	37,095,952	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,151,577	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	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME (SPECIFY)	545,045	24.00
25.00	Total other income (sum of lines 6-24)	545,045	25.00
26.00	Total (line 5 plus line 25)	-606,532	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-606,532	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0075	Period: From 10/01/2017 To 09/30/2018	Worksheet L Parts I-III Date/Time Prepared: 2/28/2019 4:45 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	248,881	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,997	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)	12.28	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)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	250,878	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