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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0160	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 11/21/2019 3:40 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/21/2019 Time: 3:40 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 INDIANA ORTHOPAEDIC HOSPITAL,LLC (15-0160) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 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	2,135	62,462	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
8.00	NURSING FACILITY	0				0	8.00
200.00	Total	0	2,135	62,462	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: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2019 3:40 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8450 NORTHWEST BOULEVARD	PO Box:			1.00
2.00	City: INDIANAPOLIS	State: IN	Zip Code: 46278	County: MARION	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	INDIANA ORTHOPAEDIC HOSPITAL,LLC	150160	26900	1	03/23/2005	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	5		21.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2019 3:40 pm

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2019 3:40 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: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2019 3:40 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2019 3:40 pm

		1.00	2.00	3.00	
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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	274,843	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2019 3:40 pm

		1.00	2.00	
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		140.00

	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:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0160	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 11/21/2019 3:40 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2019 3:40 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/18/2019	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.	N	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	03/26/2019	Y	03/26/2019	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2019 3:40 pm

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	KERRY	BEJARANO	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-383-4182	KBEJARANO@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0160	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 11/21/2019 3:40 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 MANAGING CONSULTANT		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: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2019 3:40 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	38	13,870	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)		38	13,870	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		38	13,870	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY	45.00	0	0		0	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)		38				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: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2019 3:40 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)	1,997	39	5,061			1.00
2.00	HMO and other (see instructions)	58	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,997	39	5,061			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)	1,997	39	5,061	0.00	312.09	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	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	312.09	27.00
28.00	Observation Bed Days		22	1,196			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	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2019 3:40 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	1,168	22	3,145	1.00
2.00	HMO and other (see instructions)			0	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	1,168	22	3,145	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY	0.00					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: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II | Date/Time Prepared: 11/21/2019 3:40 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	21,422,739	0	21,422,739	649,145.58	33.00	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,651,984	0	1,651,984	33,767.08	48.92	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		5,468,551	0	5,468,551	181,786.58	30.08	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,476,644	0	6,476,644			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		0	0	0			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		1,436,260	0	1,436,260			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

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 11/21/2019 3:40 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	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	1,600	0	1,600	48.50	32.99	26.00
27.00	Administrative & General	5.00	2,241,279	0	2,241,279	93,032.70	24.09	27.00
28.00	Administrative & General under contract (see inst.)		121,643	0	121,643	847.15	143.59	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,004,008	0	1,004,008	43,068.00	23.31	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		853,593	0	853,593	38,237.00	22.32	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	297,314	0	297,314	14,348.39	20.72	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: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 11/21/2019 3:40 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)		23,401,983	0	23,401,983	731,297.73	32.00	1.00
2.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		23,401,983	0	23,401,983	731,297.73	32.00	3.00
4.00	Subtotal other wages & related costs (see inst.)		7,120,535	0	7,120,535	215,553.66	33.03	4.00
5.00	Subtotal wage-related costs (see inst.)		7,912,904	0	7,912,904	0.00	33.81	5.00
6.00	Total (sum of lines 3 thru 5)		38,435,422	0	38,435,422	946,851.39	40.59	6.00
7.00	Total overhead cost (see instructions)		4,519,437	0	4,519,437	189,581.74	23.84	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 11/21/2019 3:40 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,518,547	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)	3,065,207	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	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	22,070	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	146,936	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	86,689	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,582,342	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	36,834	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	18,019	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,476,644	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V | Date/Time Prepared: 11/21/2019 3:40 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	1,651,984	6,476,644	1.00
2.00	Hospital	1,651,984	6,476,644	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 11/21/2019 3:40 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)	0.276036	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,196,819	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	64,652	5.00
6.00	Medicaid charges	4,162,299	6.00
7.00	Medicaid cost (line 1 times line 6)	1,148,944	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)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	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)	651,995	798,046	1,450,041	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	179,974	798,046	978,020	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)	179,974	798,046	978,020	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,868,397	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	65,914	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	101,406	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,766,991	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,075,317	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,053,337	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,053,337	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 11/21/2019 3:40 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		10,640,877	10,640,877	71,469	10,712,346	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,600	6,476,644	6,478,244	0	6,478,244	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,241,279	23,576,166	25,817,445	125,435	25,942,880	5.00
7.00	00700	OPERATION OF PLANT	0	200,956	200,956	55,168	256,124	7.00
10.00	01000	DIETARY	0	1,522,978	1,522,978	-1,307,449	215,529	10.00
11.00	01100	CAFETERIA	0	0	0	1,307,449	1,307,449	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	297,314	192,644	489,958	0	489,958	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,958,015	1,034,331	4,992,346	0	4,992,346	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,242,830	8,706,860	18,949,690	-516,211	18,433,479	50.00
53.00	05300	ANESTHESIOLOGY	65,695	400,950	466,645	0	466,645	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	780,211	603,149	1,383,360	516,211	1,899,571	54.00
60.00	06000	LABORATORY	0	1,209,448	1,209,448	0	1,209,448	60.00
66.00	06600	PHYSICAL THERAPY	3,524,699	810,118	4,334,817	0	4,334,817	66.00
67.00	06700	OCCUPATIONAL THERAPY	311,096	23,036	334,132	0	334,132	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	28,461,371	28,461,371	-23,689,223	4,772,148	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,689,223	23,689,223	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,279,672	3,279,672	0	3,279,672	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,422,739	87,139,200	108,561,939	252,072	108,814,011	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	0	400,093	400,093	0	400,093	194.00
194.01	07951	NNS	0	414,611	414,611	-252,072	162,539	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	21,422,739	87,953,904	109,376,643	0	109,376,643	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 11/21/2019 3:40 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	843,982	11,556,328		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,718,585	8,196,829		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,977,466	20,965,414		5.00
7.00	00700	OPERATION OF PLANT	-200,956	55,168		7.00
10.00	01000	DIETARY	-576	214,953		10.00
11.00	01100	CAFETERIA	-380,805	926,644		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	0		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-15,549	474,409		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-650	4,991,696		30.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,464	18,431,015		50.00
53.00	05300	ANESTHESIOLOGY	0	466,645		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-47	1,899,524		54.00
60.00	06000	LABORATORY	0	1,209,448		60.00
66.00	06600	PHYSICAL THERAPY	-16,226	4,318,591		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	334,132		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,772,148		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,689,223		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-25	3,279,647		73.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,032,197	105,781,814		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	46,965	447,058		194.00
194.01	07951	NNS	0	162,539		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,985,232	106,391,411		200.00

RECLASSIFICATIONS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 11/21/2019 3:40 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	0	1,307,449	1.00
	TOTALS		0	1,307,449	
	B - BUILDING EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	71,469	1.00
	TOTALS		0	71,469	
	C - A&G EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	125,435	1.00
	TOTALS		0	125,435	
	D - PLANT OPERATIONS EXPENSE				
1.00	OPERATION OF PLANT	7.00	0	55,168	1.00
	TOTALS		0	55,168	
	E - IMPLANTABLE DEVICE RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	23,689,223	1.00
	TOTALS		0	23,689,223	
	F - RADIOLOGY RECLASS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	516,211	0	1.00
	TOTALS		516,211	0	
500.00	Grand Total: Increases		516,211	25,248,744	500.00

RECLASSIFICATIONS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 11/21/2019 3:40 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	0	1,307,449	0		1.00
	TOTALS		0	1,307,449			
	B - BUILDING EXPENSE						
1.00	NNS	194.01	0	71,469	9		1.00
	TOTALS		0	71,469			
	C - A&G EXPENSE						
1.00	NNS	194.01	0	125,435	0		1.00
	TOTALS		0	125,435			
	D - PLANT OPERATIONS EXPENSE						
1.00	NNS	194.01	0	55,168	0		1.00
	TOTALS		0	55,168			
	E - IMPLANTABLE DEVICE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	23,689,223	0		1.00
	TOTALS		0	23,689,223			
	F - RADIOLOGY RECLASS						
1.00	OPERATING ROOM	50.00	516,211	0	0		1.00
	TOTALS		516,211	0			
500.00	Grand Total: Decreases		516,211	25,248,744			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/21/2019 3:40 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	778,901	0	0	0	0	1.00
2.00	Land Improvements	723,281	123,394	0	123,394	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	30,863,698	3,110,318	0	3,110,318	1,265,532	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,365,880	3,233,712	0	3,233,712	1,265,532	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,365,880	3,233,712	0	3,233,712	1,265,532	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	778,901	0	1.00
2.00	Land Improvements	846,675	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	32,708,484	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,334,060	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	34,334,060	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 11/21/2019 3:40 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	2,410,674	7,896,759	0	103,790	229,654	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,410,674	7,896,759	0	103,790	229,654	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	10,640,877		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	10,640,877		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/21/2019 3:40 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	1,625,576	0	1,625,576	0.047346	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	32,708,484	0	32,708,484	0.952654	0	2.00
3.00	Total (sum of lines 1-2)	34,334,060	0	34,334,060	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,326,125	7,896,759	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,326,125	7,896,759	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	0	103,790	229,654	0	11,556,328	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	103,790	229,654	0	11,556,328	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 11/21/2019 3:40 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-12,187	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-113,429			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-380,805	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	-15,549	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	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 11/21/2019 3:40 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LOBBYING EXPENSE OFFSET	A	-55,892	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	APPLICATION FEE REVENUE	B	-19,750	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	REBATES	B	-76,789	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	FINES AND PENALTIES	B	-450	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	GIFT AND DONATION EXPENSE OFFSET	A	-1,078	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	GIFT AND DONATION EXPENSE OFFSET	A	-650	ADULTS & PEDIATRICS	30.00	0	33.05
33.06	GIFT AND DONATION EXPENSE OFFSET	A	-2,009	OPERATING ROOM	50.00	0	33.06
33.07	GIFT AND DONATION EXPENSE OFFSET	A	-47	RADIOLOGY-DIAGNOSTIC	54.00	0	33.07
33.08	GIFT AND DONATION EXPENSE OFFSET	A	-106	PHYSICAL THERAPY	66.00	0	33.08
33.09	GIFT AND DONATION EXPENSE OFFSET	A	-25	DRUGS CHARGED TO PATIENTS	73.00	0	33.09
33.10	LEARNING LAB REVENUE	B	-10,970	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PROVIDER TAX	A	-2,077,389	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	MARKETING EXPENSE OFFSET	A	-16,120	PHYSICAL THERAPY	66.00	0	33.12
33.13	MARKETING EXPENSE OFFSET	A	-455	OPERATING ROOM	50.00	0	33.13
33.14	MARKETING EXPENSE OFFSET	A	-576	DIETARY	10.00	0	33.14
33.15	PATIENT PHONE SERVICE	A	-200,956	OPERATION OF PLANT	7.00	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,985,232				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: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/21/2019 3:40 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	OI CRC	388,458	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	OI CHARGEBACKS	4,659,259	4,659,259	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	OIE MANAGEMENT FEE	5,468,551	9,639,959	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	OIE A&G	1,436,260	0	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	OIE BENEFITS	1,718,585	0	4.01
4.02	194.00	OTHER - NONREIMBURSABLE COST	MARKETING	46,965	0	4.02
4.03	1.00	CAP REL COSTS-BLDG & FIXT	OIE CRC	467,711	0	4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,185,789	14,299,218	5.00

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

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

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

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

6.00	C	OI PRACTICE	0.00		0.00	6.00
7.00	C	NNS	100.00		0.00	7.00
8.00	C	OI ENTERPRISES	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: 15-0160	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 11/21/2019 3:40 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	388,458	9		1.00
2.00	0	0		2.00
3.00	-4,171,408	0		3.00
4.00	1,436,260	0		4.00
4.01	1,718,585	0		4.01
4.02	46,965	0		4.02
4.03	467,711	9		4.03
5.00	-113,429			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 11/21/2019 3:40 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	11,556,328	11,556,328				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,196,829	0	0	8,196,829		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,965,414	410,373	0	857,628	22,233,415	5.00
7.00	00700	OPERATION OF PLANT	55,168	2,796,344	0	0	2,851,512	7.00
10.00	01000	DIETARY	214,953	125,786	0	0	340,739	10.00
11.00	01100	CAFETERIA	926,644	208,125	0	0	1,134,769	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	167,913	0	0	167,913	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	474,409	0	0	113,767	588,176	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,991,696	2,274,316	0	1,514,538	8,780,550	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,431,015	4,146,576	0	3,721,910	26,299,501	50.00
53.00	05300	ANESTHESIOLOGY	466,645	0	0	25,138	491,783	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,899,524	532,527	0	496,077	2,928,128	54.00
60.00	06000	LABORATORY	1,209,448	102,676	0	0	1,312,124	60.00
66.00	06600	PHYSICAL THERAPY	4,318,591	706,184	0	1,348,730	6,373,505	66.00
67.00	06700	OCCUPATIONAL THERAPY	334,132	0	0	119,041	453,173	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,772,148	0	0	0	4,772,148	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,689,223	0	0	0	23,689,223	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,279,647	85,508	0	0	3,365,155	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	105,781,814	11,556,328	0	8,196,829	105,781,814	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	447,058	0	0	0	447,058	194.00
194.01	07951	NNS	162,539	0	0	0	162,539	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	106,391,411	11,556,328	0	8,196,829	106,391,411	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 11/21/2019 3:40 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
			5.00	7.00	10.00	11.00	12.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,233,415					5.00
7.00	00700	OPERATION OF PLANT	753,332	3,604,844				7.00
10.00	01000	DIETARY	90,019	54,307	485,065			10.00
11.00	01100	CAFETERIA	299,791	89,855	416,420	1,940,835		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	44,360	72,494	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	155,388	0	0	50,079	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,319,707	981,908	68,645	405,728	0	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,947,955	1,790,236	0	973,282	0	50.00
53.00	05300	ANESTHESIOLOGY	129,923	0	0	7,790	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	773,573	229,912	0	159,389	0	54.00
60.00	06000	LABORATORY	346,646	44,329	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	1,683,797	304,886	0	319,723	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	119,722	0	0	24,844	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,260,739	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,258,385	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	889,030	36,917	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,072,367	3,604,844	485,065	1,940,835	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	118,107	0	0	0	0	194.00
194.01	07951	NNS	42,941	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	22,233,415	3,604,844	485,065	1,940,835	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 11/21/2019 3:40 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION	0					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	284,767				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	793,643			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	21,472	12,578,010	0	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	441,405	36,452,379	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	25,288	654,784	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	65,946	4,156,948	0	54.00
60.00	06000	LABORATORY	0	0	10,038	1,713,137	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	50,305	8,732,216	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,977	601,716	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	47,745	24,824	6,105,456	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	237,022	119,274	30,303,904	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	31,114	4,322,216	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	284,767	793,643	105,620,766	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	0	0	0	565,165	0	194.00
194.01	07951	NNS	0	0	0	205,480	0	194.01
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)	0	284,767	793,643	106,391,411	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 11/21/2019 3:40 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	12,578,010		30.00
45.00	04500	NURSING FACILITY	0		45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	36,452,379		50.00
53.00	05300	ANESTHESIOLOGY	654,784		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,156,948		54.00
60.00	06000	LABORATORY	1,713,137		60.00
66.00	06600	PHYSICAL THERAPY	8,732,216		66.00
67.00	06700	OCCUPATIONAL THERAPY	601,716		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,105,456		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,303,904		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,322,216		73.00
		OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	105,620,766		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	565,165		194.00
194.01	07951	NNS	205,480		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	106,391,411		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 11/21/2019 3:40 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	410,373	0	410,373	0	5.00
7.00	00700	OPERATION OF PLANT	0	2,796,344	0	2,796,344	0	7.00
10.00	01000	DIETARY	0	125,786	0	125,786	0	10.00
11.00	01100	CAFETERIA	0	208,125	0	208,125	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	167,913	0	167,913	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,274,316	0	2,274,316	0	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,146,576	0	4,146,576	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	532,527	0	532,527	0	54.00
60.00	06000	LABORATORY	0	102,676	0	102,676	0	60.00
66.00	06600	PHYSICAL THERAPY	0	706,184	0	706,184	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
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	85,508	0	85,508	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	11,556,328	0	11,556,328	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	0	0	0	0	0	194.00
194.01	07951	NNS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	11,556,328	0	11,556,328	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 11/21/2019 3:40 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
			5.00	7.00	10.00	11.00	12.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	410,373					5.00
7.00	00700	OPERATION OF PLANT	13,904	2,810,248				7.00
10.00	01000	DIETARY	1,661	42,336	169,783			10.00
11.00	01100	CAFETERIA	5,533	70,049	145,756	429,463		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	819	56,515	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,868	0	0	11,081	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,814	765,472	24,027	89,778	0	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	128,254	1,395,622	0	215,366	0	50.00
53.00	05300	ANESTHESIOLOGY	2,398	0	0	1,724	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,278	179,234	0	35,269	0	54.00
60.00	06000	LABORATORY	6,398	34,558	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	31,077	237,682	0	70,748	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,210	0	0	5,497	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,269	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	115,509	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,408	28,780	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	407,400	2,810,248	169,783	429,463	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	2,180	0	0	0	0	194.00
194.01	07951	NNS	793	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	410,373	2,810,248	169,783	429,463	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 11/21/2019 3:40 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION	0					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	225,247				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	13,949			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	373	3,196,780	0	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	7,835	5,893,653	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	439	4,561	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,145	762,453	0	54.00
60.00	06000	LABORATORY	0	0	174	143,806	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	873	1,046,564	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	69	7,776	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	37,767	431	61,467	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	187,480	2,070	305,059	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	540	131,236	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	225,247	13,949	11,553,355	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	0	0	0	2,180	0	194.00
194.01	07951	NNS	0	0	0	793	0	194.01
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)	0	225,247	13,949	11,556,328	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 11/21/2019 3:40 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,196,780		30.00
45.00	04500	NURSING FACILITY	0		45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	5,893,653		50.00
53.00	05300	ANESTHESIOLOGY	4,561		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	762,453		54.00
60.00	06000	LABORATORY	143,806		60.00
66.00	06600	PHYSICAL THERAPY	1,046,564		66.00
67.00	06700	OCCUPATIONAL THERAPY	7,776		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,467		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	305,059		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	131,236		73.00
		OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,553,355		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	2,180		194.00
194.01	07951	NNS	793		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	11,556,328		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 11/21/2019 3:40 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	175,018					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	21,421,139			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,215	0	2,241,279	-22,233,415	84,157,996	5.00
7.00	00700	OPERATION OF PLANT	42,350	0	0	0	2,851,512	7.00
10.00	01000	DIETARY	1,905	0	0	0	340,739	10.00
11.00	01100	CAFETERIA	3,152	0	0	0	1,134,769	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,543	0	0	0	167,913	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	297,314	0	588,176	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,444	0	3,958,015	0	8,780,550	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	62,799	0	9,726,619	0	26,299,501	50.00
53.00	05300	ANESTHESIOLOGY	0	0	65,695	0	491,783	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,065	0	1,296,422	0	2,928,128	54.00
60.00	06000	LABORATORY	1,555	0	0	0	1,312,124	60.00
66.00	06600	PHYSICAL THERAPY	10,695	0	3,524,699	0	6,373,505	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	311,096	0	453,173	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,772,148	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	23,689,223	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,295	0	0	0	3,365,155	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	175,018	0	21,421,139	-22,233,415	83,548,399	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	0	0	0	0	447,058	194.00
194.01	07951	NNS	0	0	0	0	162,539	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	11,556,328	0	8,196,829		22,233,415	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	66.029368	0.000000	0.382651		0.264187	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		410,373	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.004876	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: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 11/21/2019 3:40 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			7.00	10.00	11.00	12.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	126,453					7.00
10.00	01000	DIETARY	1,905	126,839				10.00
11.00	01100	CAFETERIA	3,152	108,889	556,063			11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,543	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	14,348	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,444	17,950	116,244	0	0	30.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	62,799	0	278,852	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,232	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,065	0	45,666	0	0	54.00
60.00	06000	LABORATORY	1,555	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	10,695	0	91,603	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	7,118	0	0	67.00
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	1,295	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	126,453	126,839	556,063	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	0	0	0	0	0	194.00
194.01	07951	NNS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,604,844	485,065	1,940,835	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.507382	3.824258	3.490315	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,810,248	169,783	429,463	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	22.223656	1.338571	0.772328	0.000000	0.000000	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: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 11/21/2019 3:40 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			14.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,461,371			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	382,634,157		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	10,352,782		30.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	212,799,909		50.00
53.00	05300	ANESTHESIOLOGY	0	12,192,978		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,796,290		54.00
60.00	06000	LABORATORY	0	4,839,799		60.00
66.00	06600	PHYSICAL THERAPY	0	24,255,022		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,917,387		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,772,148	11,969,024		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,689,223	57,509,129		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,001,837		73.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,461,371	382,634,157		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OTHER - NONREIMBURSABLE COSTS	0	0		194.00
194.01	07951	NNS	0	0		194.01
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	284,767	793,643		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.010005	0.002074		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	225,247	13,949		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.007914	0.000036		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 11/21/2019 3:40 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,578,010		12,578,010	0	12,578,010	30.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,452,379		36,452,379	0	36,452,379	50.00
53.00	05300	ANESTHESIOLOGY	654,784		654,784	0	654,784	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,156,948		4,156,948	0	4,156,948	54.00
60.00	06000	LABORATORY	1,713,137		1,713,137	0	1,713,137	60.00
66.00	06600	PHYSICAL THERAPY	8,732,216	0	8,732,216	0	8,732,216	66.00
67.00	06700	OCCUPATIONAL THERAPY	601,716	0	601,716	0	601,716	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,105,456		6,105,456	0	6,105,456	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,303,904		30,303,904	0	30,303,904	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,322,216		4,322,216	0	4,322,216	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,404,235		2,404,235		2,404,235	92.00
200.00		Subtotal (see instructions)	108,025,001	0	108,025,001	0	108,025,001	200.00
201.00		Less Observation Beds	2,404,235		2,404,235		2,404,235	201.00
202.00		Total (see instructions)	105,620,766	0	105,620,766	0	105,620,766	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 11/21/2019 3:40 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,349,092		8,349,092			30.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	82,994,130	129,805,779	212,799,909	0.171299	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	2,998,850	9,194,128	12,192,978	0.053702	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	602,478	31,193,812	31,796,290	0.130737	0.000000	54.00
60.00	06000	LABORATORY	2,137,939	2,701,860	4,839,799	0.353969	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	2,907,265	21,347,757	24,255,022	0.360017	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	120,058	1,797,329	1,917,387	0.313821	0.000000	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,668,041	7,300,983	11,969,024	0.510105	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,429,145	35,079,984	57,509,129	0.526941	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,429,863	9,571,974	15,001,837	0.288112	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	74,855	1,928,835	2,003,690	1.199904	0.000000	92.00
200.00		Subtotal (see instructions)	132,711,716	249,922,441	382,634,157			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	132,711,716	249,922,441	382,634,157			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 11/21/2019 3:40 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
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.171299		50.00
53.00	05300	ANESTHESIOLOGY	0.053702		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.130737		54.00
60.00	06000	LABORATORY	0.353969		60.00
66.00	06600	PHYSICAL THERAPY	0.360017		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.313821		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.510105		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.526941		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288112		73.00
		OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.199904		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 11/21/2019 3:40 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	12,578,010		12,578,010	0	12,578,010	30.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,452,379		36,452,379	0	36,452,379	50.00
53.00	05300	ANESTHESIOLOGY	654,784		654,784	0	654,784	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,156,948		4,156,948	0	4,156,948	54.00
60.00	06000	LABORATORY	1,713,137		1,713,137	0	1,713,137	60.00
66.00	06600	PHYSICAL THERAPY	8,732,216	0	8,732,216	0	8,732,216	66.00
67.00	06700	OCCUPATIONAL THERAPY	601,716	0	601,716	0	601,716	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,105,456		6,105,456	0	6,105,456	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,303,904		30,303,904	0	30,303,904	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,322,216		4,322,216	0	4,322,216	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,404,235		2,404,235		2,404,235	92.00
200.00		Subtotal (see instructions)	108,025,001	0	108,025,001	0	108,025,001	200.00
201.00		Less Observation Beds	2,404,235		2,404,235		2,404,235	201.00
202.00		Total (see instructions)	105,620,766	0	105,620,766	0	105,620,766	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 11/21/2019 3:40 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,349,092		8,349,092			30.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	82,994,130	129,805,779	212,799,909	0.171299	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	2,998,850	9,194,128	12,192,978	0.053702	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	602,478	31,193,812	31,796,290	0.130737	0.000000	54.00
60.00	06000	LABORATORY	2,137,939	2,701,860	4,839,799	0.353969	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	2,907,265	21,347,757	24,255,022	0.360017	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	120,058	1,797,329	1,917,387	0.313821	0.000000	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,668,041	7,300,983	11,969,024	0.510105	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,429,145	35,079,984	57,509,129	0.526941	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,429,863	9,571,974	15,001,837	0.288112	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	74,855	1,928,835	2,003,690	1.199904	0.000000	92.00
200.00		Subtotal (see instructions)	132,711,716	249,922,441	382,634,157			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	132,711,716	249,922,441	382,634,157			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 11/21/2019 3:40 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
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
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
		OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 11/21/2019 3:40 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	3,196,780	0	3,196,780	6,257	510.91	30.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	3,196,780		3,196,780	6,257		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	1,997	1,020,287	30.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30 through 199)	1,997	1,020,287	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 11/21/2019 3:40 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	5,893,653	212,799,909	0.027696	24,677,233	683,461	50.00
53.00	05300	ANESTHESIOLOGY	4,561	12,192,978	0.000374	1,123,633	420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	762,453	31,796,290	0.023979	258,688	6,203	54.00
60.00	06000	LABORATORY	143,806	4,839,799	0.029713	702,355	20,869	60.00
66.00	06600	PHYSICAL THERAPY	1,046,564	24,255,022	0.043148	1,134,032	48,931	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,776	1,917,387	0.004056	44,230	179	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,467	11,969,024	0.005136	1,640,631	8,426	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	305,059	57,509,129	0.005305	14,847,091	78,764	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	131,236	15,001,837	0.008748	1,976,225	17,288	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	611,051	2,003,690	0.304963	74,855	22,828	92.00
200.00		Total (lines 50 through 199)	8,967,626	374,285,065		46,478,973	887,369	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 11/21/2019 3:40 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
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
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	6,257	0.00	1,997	30.00
45.00	04500	NURSING FACILITY		0	0	0.00	0	45.00
200.00		Total (lines 30 through 199)		0	6,257		1,997	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
45.00	04500	NURSING FACILITY	0	45.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 11/21/2019 3:40 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
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
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 11/21/2019 3:40 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	212,799,909	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,192,978	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	31,796,290	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	4,839,799	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	24,255,022	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,917,387	0.000000	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,969,024	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	57,509,129	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,001,837	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,003,690	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	374,285,065		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 11/21/2019 3:40 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	24,677,233	0	25,532,771	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,123,633	0	1,600,370	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	258,688	0	6,385,807	0	54.00
60.00	06000	LABORATORY	0.000000	702,355	0	216,064	0	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,134,032	0	135,769	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	44,230	0	15,128	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,640,631	0	1,008,282	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	14,847,091	0	2,393,450	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,976,225	0	1,646,283	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	74,855	0	424,235	0	92.00
200.00		Total (lines 50 through 199)		46,478,973	0	39,358,159	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 11/21/2019 3:40 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	0.171299	25,532,771	0	0	4,373,738	50.00
53.00	05300	ANESTHESIOLOGY	0.053702	1,600,370	0	0	85,943	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.130737	6,385,807	0	0	834,861	54.00
60.00	06000	LABORATORY	0.353969	216,064	0	0	76,480	60.00
66.00	06600	PHYSICAL THERAPY	0.360017	135,769	0	0	48,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.313821	15,128	0	0	4,747	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.510105	1,008,282	0	0	514,330	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.526941	2,393,450	0	0	1,261,207	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288112	1,646,283	0	0	474,314	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.199904	424,235	0	0	509,041	92.00
200.00		Subtotal (see instructions)		39,358,159	0	0	8,183,540	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		39,358,159	0	0	8,183,540	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 11/21/2019 3:40 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
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	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 11/21/2019 3:40 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	0.171299	0	1,697,653	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.053702	0	123,849	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.130737	0	555,796	0	0	54.00
60.00	06000	LABORATORY	0.353969	0	30,134	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.360017	0	252,446	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.313821	0	10,124	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.510105	0	92,793	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.526941	0	453,049	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288112	0	196,748	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.199904	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	3,412,592	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	3,412,592	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 11/21/2019 3:40 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	290,806	0		50.00
53.00	05300	ANESTHESIOLOGY	6,651	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,663	0		54.00
60.00	06000	LABORATORY	10,667	0		60.00
66.00	06600	PHYSICAL THERAPY	90,885	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,177	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,334	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	238,730	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,685	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	817,598	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	817,598	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 11/21/2019 3:40 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)	6,257	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,257	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,061	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)	1,997	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)	12,578,010	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)	12,578,010	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	12,578,010	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)	2,010.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,014,429	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)	4,014,429	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 11/21/2019 3:40 pm

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	14,311,737	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	18,326,166	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,020,287	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	887,369	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,907,656	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	16,418,510	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,196	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,010.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,404,235	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 11/21/2019 3:40 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	3,196,780	12,578,010	0.254156	2,404,235	611,051	90.00
91.00	Nursing School cost	0	12,578,010	0.000000	2,404,235	0	91.00
92.00	Allied health cost	0	12,578,010	0.000000	2,404,235	0	92.00
93.00	All other Medical Education	0	12,578,010	0.000000	2,404,235	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 11/21/2019 3:40 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,257	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,257	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,061	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)	39	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)	12,578,010	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)	12,578,010	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	12,578,010	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)	2,010.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	78,399	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)	78,399	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 11/21/2019 3:40 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	165,053	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	243,452	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,196	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,010.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,404,235	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 11/21/2019 3:40 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,196,780	12,578,010	0.254156	2,404,235	611,051	90.00
91.00	Nursing School cost	0	12,578,010	0.000000	2,404,235	0	91.00
92.00	Allied health cost	0	12,578,010	0.000000	2,404,235	0	92.00
93.00	All other Medical Education	0	12,578,010	0.000000	2,404,235	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 11/21/2019 3:40 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		3,357,031		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.171299	24,677,233	4,227,185	50.00
53.00	05300	ANESTHESIOLOGY	0.053702	1,123,633	60,341	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.130737	258,688	33,820	54.00
60.00	06000	LABORATORY	0.353969	702,355	248,612	60.00
66.00	06600	PHYSICAL THERAPY	0.360017	1,134,032	408,271	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.313821	44,230	13,880	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.510105	1,640,631	836,894	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.526941	14,847,091	7,823,541	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288112	1,976,225	569,374	73.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.199904	74,855	89,819	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		46,478,973	14,311,737	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)		46,478,973		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 11/21/2019 3:40 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		102,412		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.171299	415,403	71,158	50.00
53.00	05300	ANESTHESIOLOGY	0.053702	17,556	943	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.130737	4,081	534	54.00
60.00	06000	LABORATORY	0.353969	15,578	5,514	60.00
66.00	06600	PHYSICAL THERAPY	0.360017	19,167	6,900	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.313821	653	205	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.510105	22,706	11,582	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.526941	110,858	58,416	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288112	34,019	9,801	73.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.199904	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		640,021	165,053	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)		640,021		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0160	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 11/21/2019 3:40 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)	11,535,308	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,083,938	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)	86,098	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	518,295	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	34.72	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)	0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)	0.00	31.00
32.00	Sum of lines 30 and 31	0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0160	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 11/21/2019 3:40 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)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000003718	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	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		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	15,705,344		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	15,705,344	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,320,188	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)	17,025,532	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	17,025,532	61.00
62.00	Deductibles billed to program beneficiaries	1,482,040	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	3,350	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	2,178	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,350	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	15,545,670	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)	0	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A | Date/Time Prepared: 11/21/2019 3:40 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)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		15,545,670	71.00
71.01	Sequestration adjustment (see instructions)		310,913	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		15,232,622	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)		2,135	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.00000000000	0.00000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part B Date/Time Prepared: 11/21/2019 3:40 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	8,183,540	2.00
3.00	OPPS payments	8,129,811	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	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)	8,129,811	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	36,430	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,498,315	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)	6,595,066	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)	6,595,066	30.00
31.00	Primary payer payments	9,288	31.00
32.00	Subtotal (line 30 minus line 31)	6,585,778	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)	98,056	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	63,736	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	98,056	36.00
37.00	Subtotal (see instructions)	6,649,514	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	6,649,514	40.00
40.01	Sequestration adjustment (see instructions)	132,990	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	6,454,062	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	62,462	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: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2019 3:40 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		15,232,622		6,454,062	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)		15,232,622		6,454,062	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		2,135		62,462	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		15,234,757		6,516,524	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0160	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/21/2019 3:40 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	243,452		1.00
2.00	Medical and other services		817,598	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	243,452	817,598	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	243,452	817,598	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	102,412		8.00
9.00	Ancillary service charges	640,021	3,412,592	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	742,433	3,412,592	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	742,433	3,412,592	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	498,981	2,594,994	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	243,452	817,598	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	243,452	817,598	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	243,452	817,598	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	243,452	817,598	36.00
37.00	TO ZERO OUT MEDICAID	-243,452	-817,598	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 11/21/2019 3:40 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	11,871,153	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	49,135,426	0	0	0	4.00
5.00	Other receivable	-30,154	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-25,956,764	0	0	0	6.00
7.00	Inventory	910,754	0	0	0	7.00
8.00	Prepaid expenses	1,422,502	0	0	0	8.00
9.00	Other current assets	1,267,083	0	0	0	9.00
10.00	Due from other funds	17,786	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	38,637,786	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	4,947,195	0	0	0	12.00
13.00	Land improvements	3,337,909	0	0	0	13.00
14.00	Accumulated depreciation	-150,425	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	32,708,481	0	0	0	23.00
24.00	Accumulated depreciation	-24,643,204	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	16,199,956	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	54,837,742	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,217,979	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,723,055	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	600,391	0	0	0	43.00
44.00	Other current liabilities	2,222,427	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,763,852	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,606,368	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)	2,606,368	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,370,220	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	39,467,522				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)	39,467,522	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	54,837,742	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 11/21/2019 3:40 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		37,268,074		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		62,391,468				2.00
3.00	Total (sum of line 1 and line 2)		99,659,542		0		3.00
4.00	MEMBERSHIP ISSUED	287,980		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)		287,980		0		10.00
11.00	Subtotal (line 3 plus line 10)		99,947,522		0		11.00
12.00	DISTRIBUTIONS & MEMBERSHIP REDEEMED	60,480,000		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)		60,480,000		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		39,467,522		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	MEMBERSHIP ISSUED		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	DISTRIBUTIONS & MEMBERSHIP REDEEMED		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: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/21/2019 3:40 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,381,666		10,381,666	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	10,381,666		10,381,666	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,381,666		10,381,666	17.00
18.00	Ancillary services	124,367,880	247,884,611	372,252,491	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	134,749,546	247,884,611	382,634,157	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		109,376,643		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)		109,376,643		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0160 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 11/21/2019 3:40 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	382,634,157	1.00
2.00	Less contractual allowances and discounts on patients' accounts	212,559,393	2.00
3.00	Net patient revenues (line 1 minus line 2)	170,074,764	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	109,376,643	4.00
5.00	Net income from service to patients (line 3 minus line 4)	60,698,121	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	12,187	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	380,805	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	APPLICATION FEE & LEARNING LAB	30,720	24.00
24.01	OTHER MISCELLANEOUS INCOME	1,269,635	24.01
25.00	Total other income (sum of lines 6-24)	1,693,347	25.00
26.00	Total (line 5 plus line 25)	62,391,468	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)	62,391,468	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0160	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 11/21/2019 3:40 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,298,393	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	21,795	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)	13.87	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)	1,320,188	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