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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1328	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/28/2019 12:16 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/28/2019 Time: 12:16 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 UNIVERSITY HEALTH BEDFORD (15-1328) 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.

[X] 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) MICHAEL CRAIG
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
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	145,096	-402,036	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	418	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	145,514	-402,036	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: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:16 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2900 WEST SIXTEENTH STREET	PO Box:			1.00
2.00	City: BEDFORD	State: IN	Zip Code: 47421-	County: LAWRENCE	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 UNIVERSITY HEALTH BEDFORD	151328	99915	1	10/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IU HEALTH BEDFORD - SWING BED	15Z328	99915		10/01/2005	N	O	O	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: 1.00	To: 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)	2		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			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1328	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:16 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.	2		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.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

		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)				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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1328	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:16 pm

			1.00	
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

		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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	61,055	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:16 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: INDIANA UNIVERSITY HEALTH, INC	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	143.00

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

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

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

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

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

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

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

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

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	Y	139	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 12:16 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		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		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)	Y	04/03/2019	Y	04/03/2019	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: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 12:16 pm

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

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093	RUTTER@IUHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 12:16 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.	DIRECTOR		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: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2019 12:16 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	19	6,935	69,744.00	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)		19	6,935	69,744.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	21,600.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	91,344.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2019 12:16 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)	1,656	53	2,906			1.00
2.00	HMO and other (see instructions)	626	411				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	18	0	18			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	18			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,674	53	2,942			7.00
8.00	INTENSIVE CARE UNIT	460	17	900			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)	2,134	70	3,842	0.00	214.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			8			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	214.00	27.00
28.00	Observation Bed Days		26	1,514			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: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/28/2019 12:16 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	584	23	1,095	1.00
2.00	HMO and other (see instructions)			160	129		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	584	23	1,095	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/28/2019 12:16 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)	0.231124	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,637,573	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	34,371,993	6.00
7.00	Medicaid cost (line 1 times line 6)	7,944,193	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,306,620	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,306,620	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,362,298	150,385	3,512,683	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	777,108	150,385	927,493	21.00
22.00	Payments received from patients for amounts previously written off as charity care	9,090	2,186	11,276	22.00
23.00	Cost of charity care (line 21 minus line 22)	768,018	148,199	916,217	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)	4,765,853	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,056,237	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,624,980	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,140,873	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,294,674	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,210,891	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,517,511	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/28/2019 12:16 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		0	0	653,090	653,090	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	917,906	917,906	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	23,204	252,707	275,911	2,435,524	2,711,435	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	877,579	12,465,266	13,342,845	-207,653	13,135,192	5.00
7.00	00700	OPERATION OF PLANT	413,469	1,946,367	2,359,836	-297,353	2,062,483	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	122,476	122,476	-1,266	121,210	8.00
9.00	00900	HOUSEKEEPING	367,622	322,346	689,968	-148,101	541,867	9.00
10.00	01000	DIETARY	374,789	298,358	673,147	-252,381	420,766	10.00
11.00	01100	CAFETERIA	0	0	0	154,061	154,061	11.00
13.00	01300	NURSING ADMINISTRATION	1,560,086	2,059,465	3,619,551	-315,103	3,304,448	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	51,094	116,966	168,060	963,703	1,131,763	14.00
15.00	01500	PHARMACY	430,930	10,169,502	10,600,432	-9,652,945	947,487	15.00
17.00	01700	SOCIAL SERVICE	0	0	0	48,242	48,242	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,010,315	1,263,445	3,273,760	-562,390	2,711,370	30.00
31.00	03100	INTENSIVE CARE UNIT	931,468	486,023	1,417,491	-305,001	1,112,490	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,045,277	1,857,846	2,903,123	-1,005,974	1,897,149	50.00
51.00	05100	RECOVERY ROOM	274,469	70,581	345,050	-45,734	299,316	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	959,880	889,259	1,849,139	-473,813	1,375,326	54.00
56.00	05600	RADIOISOTOPE	72,484	187,148	259,632	-108,353	151,279	56.00
57.00	05700	CT SCAN	307,095	341,075	648,170	-228,436	419,734	57.00
58.00	05800	MRI	136,671	191,872	328,543	-55,010	273,533	58.00
60.00	06000	LABORATORY	281,524	4,518,312	4,799,836	-31,456	4,768,380	60.00
65.00	06500	RESPIRATORY THERAPY	645,894	287,476	933,370	-231,094	702,276	65.00
66.00	06600	PHYSICAL THERAPY	609,533	169,467	779,000	-115,227	663,773	66.00
67.00	06700	OCCUPATIONAL THERAPY	293,781	47,011	340,792	-18,734	322,058	67.00
68.00	06800	SPEECH PATHOLOGY	67,208	19,955	87,163	-17,038	70,125	68.00
69.00	06900	ELECTROCARDIOLOGY	296,561	574,418	870,979	-157,838	713,141	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	185,653	185,653	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	180,416	180,416	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,626,437	9,626,437	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	62,427	62,427	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	733,052	324,060	1,057,112	-184,489	872,623	90.00
90.01	09001	CLINIC - DIABETES	440	86,887	87,327	-188	87,139	90.01
91.00	09100	EMERGENCY	1,687,787	1,424,426	3,112,213	-493,594	2,618,619	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,452,212	40,492,714	54,944,926	318,288	55,263,214	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,592	9,470	24,062	-7,445	16,617	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	263,426	263,426	-263,426	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	23,014	23,014	-437	22,577	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	156,409	61,296	217,705	-46,939	170,766	194.02
194.03	07953	HOME CARE	0	41	41	-41	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	14,623,213	40,849,961	55,473,174	0	55,473,174	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/28/2019 12:16 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	115,974	769,064	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	76,739	994,645	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	202,702	2,914,137	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,591,084	10,544,108	5.00
7.00	00700	OPERATION OF PLANT	-59,105	2,003,378	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-782	120,428	8.00
9.00	00900	HOUSEKEEPING	-3,233	538,634	9.00
10.00	01000	DIETARY	0	420,766	10.00
11.00	01100	CAFETERIA	-109,525	44,536	11.00
13.00	01300	NURSING ADMINISTRATION	-542,690	2,761,758	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-4	1,131,759	14.00
15.00	01500	PHARMACY	80,762	1,028,249	15.00
17.00	01700	SOCIAL SERVICE	0	48,242	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-381,826	2,329,544	30.00
31.00	03100	INTENSIVE CARE UNIT	-95,457	1,017,033	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-1,028,098	869,051	50.00
51.00	05100	RECOVERY ROOM	0	299,316	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-37,611	1,337,715	54.00
56.00	05600	RADIOISOTOPE	0	151,279	56.00
57.00	05700	CT SCAN	0	419,734	57.00
58.00	05800	MRI	0	273,533	58.00
60.00	06000	LABORATORY	-264,270	4,504,110	60.00
65.00	06500	RESPIRATORY THERAPY	-57,421	644,855	65.00
66.00	06600	PHYSICAL THERAPY	-1,802	661,971	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	322,058	67.00
68.00	06800	SPEECH PATHOLOGY	0	70,125	68.00
69.00	06900	ELECTROCARDIOLOGY	-2,333	710,808	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	185,653	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	180,416	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,626,437	73.00
76.97	07697	CARDIAC REHABILITATION	0	62,427	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	872,623	90.00
90.01	09001	CLINIC - DIABETES	54,214	141,353	90.01
91.00	09100	EMERGENCY	-42,758	2,575,861	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,687,608	50,575,606	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,617	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	22,577	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	170,766	194.02
194.03	07953	HOME CARE	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,687,608	50,785,566	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,408,686	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	0		0	2,408,686	
	B - DIETARY/CAFETERIA				
1.00	CAFETERIA	11.00	80,424	73,637	1.00
	0		80,424	73,637	
	C - CAPITAL LEASE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	16,399	1.00
	0		0	16,399	
	D - CARDIOLOGY				
1.00	CARDIAC REHABILITATION	76.97	52,860	9,567	1.00
	0		52,860	9,567	
	E - DEPR EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	596,095	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	908,751	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
	0		0	1,504,846	
	F - BILLABLE DRUGS				
1.00	RADIOISOTOPE	56.00	0	5,024	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	9,626,437	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	0		0	9,631,461	
	G - IMPLANT SUPPLIES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	180,416	1.00
2.00		0.00	0	0	2.00
	0		0	180,416	
	H - ACCRUED PTO				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	28,565	1.00
2.00	HOUSEKEEPING	9.00	0	1,436	2.00
3.00	NURSING ADMINISTRATION	13.00	0	4,365	3.00
4.00	OPERATING ROOM	50.00	0	2,595	4.00
5.00	RECOVERY ROOM	51.00	0	4,541	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,315	6.00
7.00	OCCUPATIONAL THERAPY	67.00	0	5,936	7.00
8.00	CLINIC	90.00	0	1,929	8.00
9.00	EMERGENCY	91.00	0	22,300	9.00
10.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	892	10.00
11.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	62	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	0		0	78,936	
	I - BILLABLE MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	185,653	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	0		0	185,653	
	J - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	40,596	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,155	2.00
	0		0	49,751	
	L - SOCIAL WORKER				
1.00	SOCIAL SERVICE	17.00	48,242	0	1.00
	0		48,242	0	
	N - NON-BILLABLE SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	988,614	1.00
2.00	PHARMACY	15.00	0	4,216	2.00
3.00	CLINIC - DIABETES	90.01	0	6	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	0		0	992,836	
	O - NON-BILLABLE DRUGS				
1.00	PHARMACY	15.00	0	16,878	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 Date/Time Prepared: 5/28/2019 12:16 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
9.00		0.00	0	0	9.00
	0		0	16,878	
500.00	Grand Total: Increases		181,526	15,149,066	500.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 12:16 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	71,358	0	1.00
2.00	OPERATION OF PLANT	7.00	0	85,915	0	2.00
3.00	HOUSEKEEPING	9.00	0	116,889	0	3.00
4.00	DIETARY	10.00	0	80,810	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	261,363	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	16,485	0	6.00
7.00	PHARMACY	15.00	0	55,575	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	374,743	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	154,073	0	9.00
10.00	OPERATING ROOM	50.00	0	151,530	0	10.00
11.00	RECOVERY ROOM	51.00	0	50,010	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	191,047	0	12.00
13.00	RADIOISOTOPE	56.00	0	14,621	0	13.00
14.00	CT SCAN	57.00	0	24,273	0	14.00
15.00	MRI	58.00	0	5,797	0	15.00
16.00	LABORATORY	60.00	0	23,110	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	116,536	0	17.00
18.00	PHYSICAL THERAPY	66.00	0	96,925	0	18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	24,670	0	19.00
20.00	SPEECH PATHOLOGY	68.00	0	14,393	0	20.00
21.00	ELECTROCARDIOLOGY	69.00	0	35,704	0	21.00
22.00	CLINIC	90.00	0	118,761	0	22.00
23.00	EMERGENCY	91.00	0	277,608	0	23.00
24.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	8,337	0	24.00
25.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	38,153	0	25.00
	0		0	2,408,686		
	B - DIETARY/CAFETERIA					
1.00	DIETARY	10.00	80,424	73,637	0	1.00
	0		80,424	73,637		
	C - CAPITAL LEASE					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	16,399	11	1.00
	0		0	16,399		
	D - CARDIOLOGY					
1.00	ELECTROCARDIOLOGY	69.00	52,860	9,567	0	1.00
	0		52,860	9,567		
	E - DEPR EXPENSE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,727	9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	80,542	9	2.00
3.00	OPERATION OF PLANT	7.00	0	209,717	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	1,266	0	4.00
5.00	HOUSEKEEPING	9.00	0	1,216	0	5.00
6.00	DIETARY	10.00	0	15,743	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	9,019	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,908	0	8.00
9.00	PHARMACY	15.00	0	43,208	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	32,226	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	92,044	0	11.00
12.00	OPERATING ROOM	50.00	0	139,204	0	12.00
13.00	RECOVERY ROOM	51.00	0	265	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	246,503	0	14.00
15.00	RADIOISOTOPE	56.00	0	86,934	0	15.00
16.00	CT SCAN	57.00	0	116,142	0	16.00
17.00	MRI	58.00	0	26,567	0	17.00
18.00	LABORATORY	60.00	0	8,346	0	18.00
19.00	RESPIRATORY THERAPY	65.00	0	16,585	0	19.00
20.00	PHYSICAL THERAPY	66.00	0	7,646	0	20.00
21.00	ELECTROCARDIOLOGY	69.00	0	20,172	0	21.00
22.00	CLINIC	90.00	0	2,188	0	22.00
23.00	CLINIC - DIABETES	90.01	0	194	0	23.00
24.00	EMERGENCY	91.00	0	86,347	0	24.00
25.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	247,027	0	25.00
26.00	OCCUPATIONAL HEALTH	194.00	0	272	0	26.00
27.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	8,797	0	27.00
28.00	HOME CARE	194.03	0	41	0	28.00
	0		0	1,504,846		
	F - BILLABLE DRUGS					
1.00	PHARMACY	15.00		9,569,096	0	1.00
2.00	OPERATING ROOM	50.00		212	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00		931	0	3.00
4.00	CT SCAN	57.00		40,478	0	4.00

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
5.00	MRI	58.00		20,005	0	5.00
6.00	RESPIRATORY THERAPY	65.00		98	0	6.00
7.00	ELECTROCARDIOLOGY	69.00		256	0	7.00
8.00	EMERGENCY	91.00		220	0	8.00
9.00	OCCUPATIONAL HEALTH	194.00		165	0	9.00
	0		0	9,631,461		
	G - IMPLANT SUPPLIES					
1.00	OPERATING ROOM	50.00		179,846	0	1.00
2.00	EMERGENCY	91.00		570	0	2.00
	0		0	180,416		
	H - ACCRUED PTO					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,831	0	1.00
2.00	OPERATION OF PLANT	7.00	0	1,573	0	2.00
3.00	DIETARY	10.00	0	344	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,027	0	4.00
5.00	PHARMACY	15.00	0	6,160	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	18,794	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	14,737	0	7.00
8.00	RADIOISOTOPE	56.00	0	1,855	0	8.00
9.00	CT SCAN	57.00	0	3,358	0	9.00
10.00	MRI	58.00	0	561	0	10.00
11.00	RESPIRATORY THERAPY	65.00	0	10,702	0	11.00
12.00	PHYSICAL THERAPY	66.00	0	1,144	0	12.00
13.00	SPEECH PATHOLOGY	68.00	0	2,645	0	13.00
14.00	ELECTROCARDIOLOGY	69.00	0	8,205	0	14.00
	0		0	78,936		
	I - BILLABLE MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00		317	0	1.00
2.00	ADULTS & PEDIATRICS	30.00		4,008	0	2.00
3.00	INTENSIVE CARE UNIT	31.00		140	0	3.00
4.00	OPERATING ROOM	50.00		162,006	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00		5,132	0	5.00
6.00	RADIOISOTOPE	56.00		7,219	0	6.00
7.00	CT SCAN	57.00		1,431	0	7.00
8.00	CLINIC	90.00		3	0	8.00
9.00	EMERGENCY	91.00		5,397	0	9.00
	0		0	185,653		
	J - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	49,751	9	1.00
2.00		0.00	0	0	9	2.00
	0		0	49,751		
	L - SOCIAL WORKER					
1.00	NURSING ADMINISTRATION	13.00	48,242	0	0	1.00
	0		48,242	0		
	N - NON-BILLABLE SUPPLIES					
1.00	ADMINISTRATIVE & GENERAL	5.00		171	0	1.00
2.00	OPERATION OF PLANT	7.00		148	0	2.00
3.00	HOUSEKEEPING	9.00		31,432	0	3.00
4.00	DIETARY	10.00		1,423	0	4.00
5.00	NURSING ADMINISTRATION	13.00		844	0	5.00
6.00	ADULTS & PEDIATRICS	30.00		128,686	0	6.00
7.00	INTENSIVE CARE UNIT	31.00		42,388	0	7.00
8.00	OPERATING ROOM	50.00		375,016	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00		33,568	0	9.00
10.00	RADIOISOTOPE	56.00		2,748	0	10.00
11.00	CT SCAN	57.00		42,207	0	11.00
12.00	MRI	58.00		2,080	0	12.00
13.00	RESPIRATORY THERAPY	65.00		86,829	0	13.00
14.00	PHYSICAL THERAPY	66.00		9,512	0	14.00
15.00	ELECTROCARDIOLOGY	69.00		31,074	0	15.00
16.00	CLINIC	90.00		61,842	0	16.00
17.00	EMERGENCY	91.00		142,817	0	17.00
18.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02		51	0	18.00
	0		0	992,836		
	O - NON-BILLABLE DRUGS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	174	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	3,933	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	1,619	0	3.00
4.00	OPERATING ROOM	50.00	0	755	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,947	0	5.00
6.00	CT SCAN	57.00	0	547	0	6.00
7.00	RESPIRATORY THERAPY	65.00	0	344	0	7.00
8.00	CLINIC	90.00	0	3,624	0	8.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 12:16 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
9.00	EMERGENCY	91.00	0	2,935	0	9.00
	0		0	16,878		
500.00	Grand Total: Decreases		181,526	15,149,066		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1328

Period: From 01/01/2018 To 12/31/2018

Worksheet A-7 Part I

Date/Time Prepared: 5/28/2019 12:16 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	931,334	0	0	0	0	1.00
2.00	Land Improvements	1,119,735	0	0	0	0	2.00
3.00	Buildings and Fixtures	14,929,250	0	0	0	0	3.00
4.00	Building Improvements	5,122,999	91,525	0	91,525	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	19,458,202	1,027,554	0	1,027,554	5,234,882	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,561,520	1,119,079	0	1,119,079	5,234,882	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	41,561,520	1,119,079	0	1,119,079	5,234,882	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	931,334	0	1.00
2.00	Land Improvements	1,119,735	0	2.00
3.00	Buildings and Fixtures	14,929,250	0	3.00
4.00	Building Improvements	5,214,524	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	15,250,874	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,445,717	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	37,445,717	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/28/2019 12:16 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	0	0	0	0	0	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	0	0	3.00

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/28/2019 12:16 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	22,194,843	639,150	21,555,693	0.585648	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,250,875	0	15,250,875	0.414352	0	2.00
3.00	Total (sum of lines 1-2)	37,445,718	639,150	36,806,568	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,441,945	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	994,645	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,436,590	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-672,881	0	0	0	769,064	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	994,645	2.00
3.00	Total (sum of lines 1-2)	-672,881	0	0	0	1,763,709	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/28/2019 12:16 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-689,280	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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	-4,128,538			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	5,338,718			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-125,858	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-983	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/28/2019 12:16 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	
34.00	MISCELLANEOUS INCOME	B	-16,391	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	MISCELLANEOUS INCOME	B	-5,063	OPERATION OF PLANT	7.00	0	35.00
36.00	MISCELLANEOUS INCOME	B	-782	LAUNDRY & LINEN SERVICE	8.00	0	36.00
37.00	MISCELLANEOUS INCOME	B	-3,233	HOUSEKEEPING	9.00	0	37.00
38.00	MISCELLANEOUS INCOME	B	-109,525	CAFETERIA	11.00	0	38.00
39.00	MISCELLANEOUS INCOME	B	-30,910	NURSING ADMINISTRATION	13.00	0	39.00
40.00	MISCELLANEOUS INCOME	B	-2,000	OPERATING ROOM	50.00	0	40.00
41.00	MISCELLANEOUS INCOME	B	-37,590	RADIOLOGY-DIAGNOSTIC	54.00	0	41.00
42.00	MISCELLANEOUS INCOME	B	-57,421	RESPIRATORY THERAPY	65.00	0	42.00
43.00	MISCELLANEOUS INCOME	B	-2,275	ELECTROCARDIOLOGY	69.00	0	43.00
45.00	PHONES	A	-8	CAP REL COSTS-BLDG & FIXT	1.00	9	45.00
45.01	PHONES	A	-2,935	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.01
45.02	PHONES	A	-3,414	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.02
45.03	PHONES	A	-20,237	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	PHONES	A	-4	CENTRAL SERVICES & SUPPLY	14.00	0	45.04
45.05	HAF	A	-2,249,588	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.07	CABLE	A	-1,802	PHYSICAL THERAPY	66.00	0	45.07
45.08	RECRUITING	A	-61,262	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	BENEFITS	A	-2,412,577	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.09
45.10	ACCRUED PTO	A	-51,769	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.10
45.11	TELEPHONE EQUIPMENT	A	0	PHYSICAL THERAPY	66.00	0	45.11
45.12	MARKETING	A	-20,515	ADMINISTRATIVE & GENERAL	5.00	0	45.12
45.13	MARKETING	A	-58	ELECTROCARDIOLOGY	69.00	0	45.13
45.14	MARKETING	A	-21	RADIOLOGY-DIAGNOSTIC	54.00	0	45.14
45.15	INVESTMENT FEES	B	7,753	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	UNWONTED SITUATIONS	A	-40	ADMINISTRATIVE & GENERAL	5.00	0	45.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,687,608				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: 15-1328	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/28/2019 12:16 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	HOME OFFICE	805,262	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	205,532	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2,770,114	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	7,789,312	7,855,637	4.00
4.01	13.00	NURSING ADMINISTRATION	HOME OFFICE	0	28,481	4.01
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	128,063	226,732	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	1,709,486	1,632,496	4.03
4.04	7.00	OPERATION OF PLANT	RELATED PARTY	0	54,042	4.04
4.05	13.00	NURSING ADMINISTRATION	RELATED PARTY	1,106,156	1,589,455	4.05
4.06	15.00	PHARMACY	RELATED PARTY	572,753	491,991	4.06
4.07	90.01	CLINIC - DIABETES	RELATED PARTY	108,360	54,146	4.07
4.08	91.00	EMERGENCY	EMERGENCY ROOM	2,725,939	649,279	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	247,469	247,469	4.09
4.10	13.00	NURSING ADMINISTRATION	SHARED EMPLOYEES	127	127	4.10
4.11	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	490,498	490,498	4.11
4.12	31.00	INTENSIVE CARE UNIT	SHARED EMPLOYEES	122,625	122,625	4.12
4.13	60.00	LABORATORY	SHARED EMPLOYEES	4,317,858	4,317,858	4.13
4.14	69.00	ELECTROCARDIOLOGY	SHARED EMPLOYEES	422,214	422,214	4.14
4.15	90.00	CLINIC	SHARED EMPLOYEES	53,067	53,067	4.15
4.16	90.01	CLINIC - DIABETES	SHARED EMPLOYEES	32,079	32,079	4.16
4.17	91.00	EMERGENCY	SHARED EMPLOYEES	12,000	12,000	4.17
4.18	194.00	OCCUPATIONAL HEALTH	SHARED EMPLOYEES	8,893	8,893	4.18
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			23,627,807	18,289,089	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	IU HEALTH, INC.	50.00	6.00
7.00	F		0.00	IUH BLOOMINGTO	50.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/28/2019 12:16 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	805,262	9	1.00
2.00	205,532	9	2.00
3.00	2,770,114	0	3.00
4.00	-66,325	0	4.00
4.01	-28,481	0	4.01
4.02	-98,669	0	4.02
4.03	76,990	0	4.03
4.04	-54,042	0	4.04
4.05	-483,299	0	4.05
4.06	80,762	0	4.06
4.07	54,214	0	4.07
4.08	2,076,660	0	4.08
4.09	0	0	4.09
4.10	0	0	4.10
4.11	0	0	4.11
4.12	0	0	4.12
4.13	0	0	4.13
4.14	0	0	4.14
4.15	0	0	4.15
4.16	0	0	4.16
4.17	0	0	4.17
4.18	0	0	4.18
5.00	5,338,718		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	HOME OFFICE		6.00
7.00	HEALTHCARE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/28/2019 12:16 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	241,469	241,469	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	490,498	381,826	108,672	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	122,625	95,457	27,168	0	0	3.00
4.00	50.00	OPERATING ROOM	1,026,098	1,026,098	0	0	0	4.00
5.00	60.00	LABORATORY	281,524	264,270	17,254	0	0	5.00
6.00	91.00	EMERGENCY	2,523,350	2,119,418	403,932	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,685,564	4,128,538	557,026		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	241,469		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	381,826		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	95,457		3.00
4.00	50.00	OPERATING ROOM	0	0	0	1,026,098		4.00
5.00	60.00	LABORATORY	0	0	0	264,270		5.00
6.00	91.00	EMERGENCY	0	0	0	2,119,418		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	4,128,538		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/28/2019 12:16 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	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	769,064	769,064				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	994,645		994,645			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,914,137	2,406	4,199	2,920,742		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,544,108	116,761	203,811	175,561	11,040,241	5.00
7.00	00700	OPERATION OF PLANT	2,003,378	86,558	151,089	82,715	2,323,740	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	120,428	3,249	5,670	0	129,347	8.00
9.00	00900	HOUSEKEEPING	538,634	8,432	14,718	73,543	635,327	9.00
10.00	01000	DIETARY	420,766	17,152	29,938	58,888	526,744	10.00
11.00	01100	CAFETERIA	44,536	11,229	19,600	16,089	91,454	11.00
13.00	01300	NURSING ADMINISTRATION	2,761,758	23,606	41,205	302,446	3,129,015	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,131,759	19,920	34,770	10,221	1,196,670	14.00
15.00	01500	PHARMACY	1,028,249	5,753	10,042	86,208	1,130,252	15.00
17.00	01700	SOCIAL SERVICE	48,242	518	904	9,651	59,315	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,329,544	41,620	72,647	402,160	2,845,971	30.00
31.00	03100	INTENSIVE CARE UNIT	1,017,033	10,706	18,688	186,341	1,232,768	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	869,051	52,123	90,982	209,109	1,221,265	50.00
51.00	05100	RECOVERY ROOM	299,316	0	0	54,908	354,224	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,337,715	21,281	37,146	192,025	1,588,167	54.00
56.00	05600	RADIOISOTOPE	151,279	0	0	14,500	165,779	56.00
57.00	05700	CT SCAN	419,734	4,623	8,070	61,435	493,862	57.00
58.00	05800	MRI	273,533	4,906	8,563	27,341	314,343	58.00
60.00	06000	LABORATORY	4,504,110	22,034	38,460	56,319	4,620,923	60.00
65.00	06500	RESPIRATORY THERAPY	644,855	6,196	10,815	129,212	791,078	65.00
66.00	06600	PHYSICAL THERAPY	661,971	12,952	22,608	121,938	819,469	66.00
67.00	06700	OCCUPATIONAL THERAPY	322,058	4,567	7,971	58,771	393,367	67.00
68.00	06800	SPEECH PATHOLOGY	70,125	1,624	2,835	13,445	88,029	68.00
69.00	06900	ELECTROCARDIOLOGY	710,808	16,436	28,689	48,753	804,686	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	185,653	0	0	0	185,653	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	180,416	0	0	0	180,416	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,626,437	0	0	0	9,626,437	73.00
76.97	07697	CARDIAC REHABILITATION	62,427	8,663	15,121	10,575	96,786	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	872,623	27,999	48,873	146,648	1,096,143	90.00
90.01	09001	CLINIC - DIABETES	141,353	2,444	4,265	88	148,150	90.01
91.00	09100	EMERGENCY	2,575,861	21,751	37,967	337,643	2,973,222	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,575,606	555,509	969,646	2,886,533	50,302,843	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,617	4,388	7,659	2,919	31,583	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	173,098	0	0	173,098	192.00
194.00	07950	OCCUPATIONAL HEALTH	22,577	9,934	17,340	0	49,851	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	170,766	26,135	0	31,290	228,191	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	50,785,566	769,064	994,645	2,920,742	50,785,566	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/28/2019 12:16 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,040,241					5.00
7.00	00700	OPERATION OF PLANT	645,477	2,969,217				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,929	17,123	182,399			8.00
9.00	00900	HOUSEKEEPING	176,478	44,444	0	856,249		9.00
10.00	01000	DIETARY	146,316	90,402	0	41,671	805,133	10.00
11.00	01100	CAFETERIA	25,404	59,184	0	27,281	0	11.00
13.00	01300	NURSING ADMINISTRATION	869,162	124,424	0	57,354	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	332,405	104,993	0	48,397	0	14.00
15.00	01500	PHARMACY	313,956	30,324	0	13,978	0	15.00
17.00	01700	SOCIAL SERVICE	16,476	2,730	0	1,258	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	790,540	219,367	62,096	101,119	614,742	30.00
31.00	03100	INTENSIVE CARE UNIT	342,432	56,430	27,559	26,012	190,391	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	339,237	274,729	37,460	126,641	0	50.00
51.00	05100	RECOVERY ROOM	98,395	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	441,153	112,165	0	51,703	0	54.00
56.00	05600	RADIOISOTOPE	46,049	0	0	0	0	56.00
57.00	05700	CT SCAN	137,183	24,369	0	11,233	0	57.00
58.00	05800	MRI	87,317	25,857	0	11,919	0	58.00
60.00	06000	LABORATORY	1,283,577	116,135	0	53,533	0	60.00
65.00	06500	RESPIRATORY THERAPY	219,742	32,657	0	15,053	0	65.00
66.00	06600	PHYSICAL THERAPY	227,628	68,267	0	31,468	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	109,268	24,071	0	11,096	0	67.00
68.00	06800	SPEECH PATHOLOGY	24,452	8,561	0	3,946	0	68.00
69.00	06900	ELECTROCARDIOLOGY	223,522	86,630	0	39,933	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,570	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	50,115	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,673,965	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	26,885	45,660	0	21,047	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	304,481	147,576	0	68,026	0	90.00
90.01	09001	CLINIC - DIABETES	41,152	12,879	0	5,937	0	90.01
91.00	09100	EMERGENCY	825,887	114,646	55,284	52,847	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,906,153	1,843,623	182,399	821,452	805,133	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,773	23,128	0	10,661	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	48,082	912,357	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	13,847	52,360	0	24,136	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	63,386	137,749	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,040,241	2,969,217	182,399	856,249	805,133	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/28/2019 12:16 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
			11.00	13.00	14.00	15.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	203,323					11.00
13.00	01300	NURSING ADMINISTRATION	18,865	4,198,820				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,096	0	1,684,561			14.00
15.00	01500	PHARMACY	6,288	0	46,865	1,541,663		15.00
17.00	01700	SOCIAL SERVICE	1,048	0	0	0	80,827	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,586	1,602,181	147,870	629	61,714	30.00
31.00	03100	INTENSIVE CARE UNIT	11,529	552,476	48,779	259	19,113	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,529	220,991	456,869	121	0	50.00
51.00	05100	RECOVERY ROOM	3,144	165,743	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,625	0	38,774	471	0	54.00
56.00	05600	RADIOISOTOPE	1,048	0	3,221	0	0	56.00
57.00	05700	CT SCAN	5,240	0	48,529	88	0	57.00
58.00	05800	MRI	2,096	0	2,654	0	0	58.00
60.00	06000	LABORATORY	20,961	0	175,140	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,433	0	97,690	55	0	65.00
66.00	06600	PHYSICAL THERAPY	9,433	55,248	11,011	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,144	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,048	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,144	110,495	35,348	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	207,056	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	201,215	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,538,989	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,048	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,577	441,981	0	582	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	25,153	1,049,705	163,478	469	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	197,035	4,198,820	1,684,499	1,541,663	80,827	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,048	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	5,240	0	62	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	203,323	4,198,820	1,684,561	1,541,663	80,827	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/28/2019 12:16 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,480,815	0	6,480,815		30.00
31.00	03100	INTENSIVE CARE UNIT	2,507,748	0	2,507,748		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,688,842	0	2,688,842		50.00
51.00	05100	RECOVERY ROOM	621,506	0	621,506		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,246,058	0	2,246,058		54.00
56.00	05600	RADIOISOTOPE	216,097	0	216,097		56.00
57.00	05700	CT SCAN	720,504	0	720,504		57.00
58.00	05800	MRI	444,186	0	444,186		58.00
60.00	06000	LABORATORY	6,270,269	0	6,270,269		60.00
65.00	06500	RESPIRATORY THERAPY	1,165,708	0	1,165,708		65.00
66.00	06600	PHYSICAL THERAPY	1,222,524	0	1,222,524		66.00
67.00	06700	OCCUPATIONAL THERAPY	540,946	0	540,946		67.00
68.00	06800	SPEECH PATHOLOGY	126,036	0	126,036		68.00
69.00	06900	ELECTROCARDIOLOGY	1,303,758	0	1,303,758		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	444,279	0	444,279		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	431,746	0	431,746		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,839,391	0	13,839,391		73.00
76.97	07697	CARDIAC REHABILITATION	191,426	0	191,426		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2,071,366	0	2,071,366		90.00
90.01	09001	CLINIC - DIABETES	208,118	0	208,118		90.01
91.00	09100	EMERGENCY	5,260,691	0	5,260,691		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,002,014	0	49,002,014		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	75,193	0	75,193		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,133,537	0	1,133,537		192.00
194.00	07950	OCCUPATIONAL HEALTH	140,194	0	140,194		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	434,628	0	434,628		194.02
194.03	07953	HOME CARE	0	0	0		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	50,785,566	0	50,785,566		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 12:16 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,406	4,199	6,605	6,605	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	116,761	203,811	320,572	397	5.00
7.00	00700	OPERATION OF PLANT	0	86,558	151,089	237,647	187	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,249	5,670	8,919	0	8.00
9.00	00900	HOUSEKEEPING	0	8,432	14,718	23,150	166	9.00
10.00	01000	DIETARY	0	17,152	29,938	47,090	133	10.00
11.00	01100	CAFETERIA	0	11,229	19,600	30,829	36	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,606	41,205	64,811	683	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,920	34,770	54,690	23	14.00
15.00	01500	PHARMACY	0	5,753	10,042	15,795	195	15.00
17.00	01700	SOCIAL SERVICE	0	518	904	1,422	22	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	41,620	72,647	114,267	914	30.00
31.00	03100	INTENSIVE CARE UNIT	0	10,706	18,688	29,394	421	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	52,123	90,982	143,105	472	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	124	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,281	37,146	58,427	434	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	33	56.00
57.00	05700	CT SCAN	0	4,623	8,070	12,693	139	57.00
58.00	05800	MRI	0	4,906	8,563	13,469	62	58.00
60.00	06000	LABORATORY	0	22,034	38,460	60,494	127	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,196	10,815	17,011	292	65.00
66.00	06600	PHYSICAL THERAPY	0	12,952	22,608	35,560	276	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,567	7,971	12,538	133	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,624	2,835	4,459	30	68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,436	28,689	45,125	110	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	8,663	15,121	23,784	24	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	27,999	48,873	76,872	331	90.00
90.01	09001	CLINIC - DIABETES	0	2,444	4,265	6,709	0	90.01
91.00	09100	EMERGENCY	0	21,751	37,967	59,718	763	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	555,509	969,646	1,525,155	6,527	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,388	7,659	12,047	7	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	173,098	0	173,098	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	9,934	17,340	27,274	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	26,135	0	26,135	71	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	769,064	994,645	1,763,709	6,605	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 12:16 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	320,969					5.00
7.00	00700	OPERATION OF PLANT	18,767	256,601				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,045	1,480	11,444			8.00
9.00	00900	HOUSEKEEPING	5,131	3,841	0	32,288		9.00
10.00	01000	DIETARY	4,254	7,813	0	1,571	60,861	10.00
11.00	01100	CAFETERIA	739	5,115	0	1,029	0	11.00
13.00	01300	NURSING ADMINISTRATION	25,270	10,753	0	2,163	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,664	9,074	0	1,825	0	14.00
15.00	01500	PHARMACY	9,128	2,621	0	527	0	15.00
17.00	01700	SOCIAL SERVICE	479	236	0	47	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,984	18,958	3,896	3,813	46,469	30.00
31.00	03100	INTENSIVE CARE UNIT	9,956	4,877	1,729	981	14,392	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,863	23,742	2,350	4,774	0	50.00
51.00	05100	RECOVERY ROOM	2,861	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,826	9,693	0	1,950	0	54.00
56.00	05600	RADIOISOTOPE	1,339	0	0	0	0	56.00
57.00	05700	CT SCAN	3,988	2,106	0	424	0	57.00
58.00	05800	MRI	2,539	2,235	0	449	0	58.00
60.00	06000	LABORATORY	37,319	10,036	0	2,019	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,389	2,822	0	568	0	65.00
66.00	06600	PHYSICAL THERAPY	6,618	5,900	0	1,187	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,177	2,080	0	418	0	67.00
68.00	06800	SPEECH PATHOLOGY	711	740	0	149	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,499	7,487	0	1,506	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,499	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,457	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,726	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	782	3,946	0	794	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,852	12,754	0	2,565	0	90.00
90.01	09001	CLINIC - DIABETES	1,196	1,113	0	224	0	90.01
91.00	09100	EMERGENCY	24,012	9,908	3,469	1,993	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	317,070	159,330	11,444	30,976	60,861	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	255	1,999	0	402	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,398	78,843	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	403	4,525	0	910	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	1,843	11,904	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	320,969	256,601	11,444	32,288	60,861	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 12:16 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
			11.00	13.00	14.00	15.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	37,748					11.00
13.00	01300	NURSING ADMINISTRATION	3,502	107,182				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	389	0	75,665			14.00
15.00	01500	PHARMACY	1,167	0	2,105	31,538		15.00
17.00	01700	SOCIAL SERVICE	195	0	0	0	2,401	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,419	40,898	6,642	13	1,833	30.00
31.00	03100	INTENSIVE CARE UNIT	2,140	14,103	2,191	5	568	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,140	5,641	20,519	2	0	50.00
51.00	05100	RECOVERY ROOM	584	4,231	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,530	0	1,742	10	0	54.00
56.00	05600	RADIOISOTOPE	195	0	145	0	0	56.00
57.00	05700	CT SCAN	973	0	2,180	2	0	57.00
58.00	05800	MRI	389	0	119	0	0	58.00
60.00	06000	LABORATORY	3,892	0	7,867	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,751	0	4,388	1	0	65.00
66.00	06600	PHYSICAL THERAPY	1,751	1,410	495	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	584	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	195	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	584	2,821	1,588	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	9,300	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	9,038	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	31,483	0	73.00
76.97	07697	CARDIAC REHABILITATION	195	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,335	11,282	0	12	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,670	26,796	7,343	10	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,580	107,182	75,662	31,538	2,401	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	195	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	973	0	3	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	37,748	107,182	75,665	31,538	2,401	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 12:16 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	267,106	0	267,106		30.00
31.00	03100	INTENSIVE CARE UNIT	80,757	0	80,757		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	212,608	0	212,608		50.00
51.00	05100	RECOVERY ROOM	7,800	0	7,800		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,612	0	87,612		54.00
56.00	05600	RADIOISOTOPE	1,712	0	1,712		56.00
57.00	05700	CT SCAN	22,505	0	22,505		57.00
58.00	05800	MRI	19,262	0	19,262		58.00
60.00	06000	LABORATORY	121,754	0	121,754		60.00
65.00	06500	RESPIRATORY THERAPY	33,222	0	33,222		65.00
66.00	06600	PHYSICAL THERAPY	53,197	0	53,197		66.00
67.00	06700	OCCUPATIONAL THERAPY	18,930	0	18,930		67.00
68.00	06800	SPEECH PATHOLOGY	6,284	0	6,284		68.00
69.00	06900	ELECTROCARDIOLOGY	65,720	0	65,720		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,799	0	10,799		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,495	0	10,495		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,209	0	109,209		73.00
76.97	07697	CARDIAC REHABILITATION	29,525	0	29,525		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	115,003	0	115,003		90.00
90.01	09001	CLINIC - DIABETES	9,242	0	9,242		90.01
91.00	09100	EMERGENCY	138,682	0	138,682		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,421,424	0	1,421,424		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,905	0	14,905		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	253,339	0	253,339		192.00
194.00	07950	OCCUPATIONAL HEALTH	33,112	0	33,112		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	40,929	0	40,929		194.02
194.03	07953	HOME CARE	0	0	0		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,763,709	0	1,763,709		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:16 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	163,349					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		121,032				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	511	511	14,600,009			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,800	24,800	877,579	-11,040,241	39,745,325	5.00
7.00	00700	OPERATION OF PLANT	18,385	18,385	413,469	0	2,323,740	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	690	690	0	0	129,347	8.00
9.00	00900	HOUSEKEEPING	1,791	1,791	367,622	0	635,327	9.00
10.00	01000	DIETARY	3,643	3,643	294,365	0	526,744	10.00
11.00	01100	CAFETERIA	2,385	2,385	80,424	0	91,454	11.00
13.00	01300	NURSING ADMINISTRATION	5,014	5,014	1,511,844	0	3,129,015	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,231	4,231	51,094	0	1,196,670	14.00
15.00	01500	PHARMACY	1,222	1,222	430,930	0	1,130,252	15.00
17.00	01700	SOCIAL SERVICE	110	110	48,242	0	59,315	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,840	8,840	2,010,315	0	2,845,971	30.00
31.00	03100	INTENSIVE CARE UNIT	2,274	2,274	931,468	0	1,232,768	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,071	11,071	1,045,277	0	1,221,265	50.00
51.00	05100	RECOVERY ROOM	0	0	274,469	0	354,224	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,520	4,520	959,880	0	1,588,167	54.00
56.00	05600	RADIOISOTOPE	0	0	72,484	0	165,779	56.00
57.00	05700	CT SCAN	982	982	307,095	0	493,862	57.00
58.00	05800	MRI	1,042	1,042	136,671	0	314,343	58.00
60.00	06000	LABORATORY	4,680	4,680	281,524	0	4,620,923	60.00
65.00	06500	RESPIRATORY THERAPY	1,316	1,316	645,894	0	791,078	65.00
66.00	06600	PHYSICAL THERAPY	2,751	2,751	609,533	0	819,469	66.00
67.00	06700	OCCUPATIONAL THERAPY	970	970	293,781	0	393,367	67.00
68.00	06800	SPEECH PATHOLOGY	345	345	67,208	0	88,029	68.00
69.00	06900	ELECTROCARDIOLOGY	3,491	3,491	243,701	0	804,686	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	185,653	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	180,416	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	9,626,437	73.00
76.97	07697	CARDIAC REHABILITATION	1,840	1,840	52,860	0	96,786	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,947	5,947	733,052	0	1,096,143	90.00
90.01	09001	CLINIC - DIABETES	519	519	440	0	148,150	90.01
91.00	09100	EMERGENCY	4,620	4,620	1,687,787	0	2,973,222	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	117,990	117,990	14,429,008	-11,040,241	39,262,602	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	932	932	14,592	0	31,583	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	36,766	0	0	0	173,098	192.00
194.00	07950	OCCUPATIONAL HEALTH	2,110	2,110	0	0	49,851	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	5,551	0	156,409	0	228,191	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	769,064	994,645	2,920,742		11,040,241	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.708104	8.218033	0.200051		0.277775	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,605		320,969	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000452		0.008076	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: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:16 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	119,653					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	690	233,392				8.00
9.00	00900	HOUSEKEEPING	1,791	0	74,855			9.00
10.00	01000	DIETARY	3,643	0	3,643	49,765		10.00
11.00	01100	CAFETERIA	2,385	0	2,385	0	194	11.00
13.00	01300	NURSING ADMINISTRATION	5,014	0	5,014	0	18	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,231	0	4,231	0	2	14.00
15.00	01500	PHARMACY	1,222	0	1,222	0	6	15.00
17.00	01700	SOCIAL SERVICE	110	0	110	0	1	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,840	79,457	8,840	37,997	33	30.00
31.00	03100	INTENSIVE CARE UNIT	2,274	35,264	2,274	11,768	11	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,071	47,932	11,071	0	11	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	3	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,520	0	4,520	0	13	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	1	56.00
57.00	05700	CT SCAN	982	0	982	0	5	57.00
58.00	05800	MRI	1,042	0	1,042	0	2	58.00
60.00	06000	LABORATORY	4,680	0	4,680	0	20	60.00
65.00	06500	RESPIRATORY THERAPY	1,316	0	1,316	0	9	65.00
66.00	06600	PHYSICAL THERAPY	2,751	0	2,751	0	9	66.00
67.00	06700	OCCUPATIONAL THERAPY	970	0	970	0	3	67.00
68.00	06800	SPEECH PATHOLOGY	345	0	345	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	3,491	0	3,491	0	3	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,840	0	1,840	0	1	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,947	0	5,947	0	12	90.00
90.01	09001	CLINIC - DIABETES	519	0	519	0	0	90.01
91.00	09100	EMERGENCY	4,620	70,739	4,620	0	24	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,294	233,392	71,813	49,765	188	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	932	0	932	0	1	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	36,766	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	2,110	0	2,110	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	5,551	0	0	0	5	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,969,217	182,399	856,249	805,133	203,323	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.815232	0.781514	11.438768	16.178700	1,048.056701	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	256,601	11,444	32,288	60,861	37,748	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.144543	0.049033	0.431341	1.222968	194.577320	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: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:16 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			13.00	14.00	15.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	76					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,510,434				14.00
15.00	01500	PHARMACY	0	42,021	9,643,160			15.00
17.00	01700	SOCIAL SERVICE	0	0	0	3,806		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29	132,585	3,932	2,906		30.00
31.00	03100	INTENSIVE CARE UNIT	10	43,737	1,619	900		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4	409,644	755	0		50.00
51.00	05100	RECOVERY ROOM	3	0	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,766	2,947	0		54.00
56.00	05600	RADIOISOTOPE	0	2,888	0	0		56.00
57.00	05700	CT SCAN	0	43,513	548	0		57.00
58.00	05800	MRI	0	2,380	0	0		58.00
60.00	06000	LABORATORY	0	157,036	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	87,592	344	0		65.00
66.00	06600	PHYSICAL THERAPY	1	9,873	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2	31,694	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	185,653	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	180,416	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	9,626,437	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8	0	3,643	0		90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0		90.01
91.00	09100	EMERGENCY	19	146,580	2,935	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76	1,510,378	9,643,160	3,806		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	56	0	0		194.02
194.03	07953	HOME CARE	0	0	0	0		194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,198,820	1,684,561	1,541,663	80,827		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	55,247.631579	1.115283	0.159871	21.236731		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	107,182	75,665	31,538	2,401		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,410.289474	0.050095	0.003271	0.630846		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: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,480,815		6,480,815	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,507,748		2,507,748	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,688,842		2,688,842	0	0	50.00
51.00	05100	RECOVERY ROOM	621,506		621,506	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,246,058		2,246,058	0	0	54.00
56.00	05600	RADIOISOTOPE	216,097		216,097	0	0	56.00
57.00	05700	CT SCAN	720,504		720,504	0	0	57.00
58.00	05800	MRI	444,186		444,186	0	0	58.00
60.00	06000	LABORATORY	6,270,269		6,270,269	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,165,708	0	1,165,708	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,222,524	0	1,222,524	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	540,946	0	540,946	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	126,036	0	126,036	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,303,758		1,303,758	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	444,279		444,279	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	431,746		431,746	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,839,391		13,839,391	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	191,426		191,426	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,071,366		2,071,366	0	0	90.00
90.01	09001	CLINIC - DIABETES	208,118		208,118	0	0	90.01
91.00	09100	EMERGENCY	5,260,691		5,260,691	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,210,107		2,210,107		0	92.00
200.00		Subtotal (see instructions)	51,212,121	0	51,212,121	0	0	200.00
201.00		Less Observation Beds	2,210,107		2,210,107		0	201.00
202.00		Total (see instructions)	49,002,014	0	49,002,014	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,236,639		5,236,639			30.00
31.00	03100	INTENSIVE CARE UNIT	5,993,812		5,993,812			31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,343,843	21,738,752	24,082,595	0.111651	0.000000	50.00
51.00	05100	RECOVERY ROOM	286,404	3,102,184	3,388,588	0.183411	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	609,334	12,363,752	12,973,086	0.173132	0.000000	54.00
56.00	05600	RADIOISOTOPE	222,802	2,186,704	2,409,506	0.089685	0.000000	56.00
57.00	05700	CT SCAN	552,797	6,615,776	7,168,573	0.100509	0.000000	57.00
58.00	05800	MRI	184,252	2,418,227	2,602,479	0.170678	0.000000	58.00
60.00	06000	LABORATORY	2,815,029	16,566,967	19,381,996	0.323510	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,083,207	2,974,033	4,057,240	0.287316	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	295,293	2,641,406	2,936,699	0.416292	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	151,936	883,686	1,035,622	0.522339	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	40,850	327,221	368,071	0.342423	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	769,218	9,840,591	10,609,809	0.122882	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	473,450	1,621,026	2,094,476	0.212119	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	124,035	1,657,646	1,781,681	0.242325	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,107,499	45,575,965	50,683,464	0.273055	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	539	1,156,107	1,156,646	0.165501	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	56	10,682,890	10,682,946	0.193895	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	75,648	75,648	2.751137	0.000000	90.01
91.00	09100	EMERGENCY	1,092,434	30,980,120	32,072,554	0.164025	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	63,102	11,161,030	11,224,132	0.196907	0.000000	92.00
200.00		Subtotal (see instructions)	27,446,531	184,569,731	212,016,262			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	27,446,531	184,569,731	212,016,262			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/28/2019 12:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
					Costs			
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,480,815		6,480,815	0	6,480,815	30.00
31.00	03100	INTENSIVE CARE UNIT	2,507,748		2,507,748	0	2,507,748	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,688,842		2,688,842	0	2,688,842	50.00
51.00	05100	RECOVERY ROOM	621,506		621,506	0	621,506	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,246,058		2,246,058	0	2,246,058	54.00
56.00	05600	RADIOISOTOPE	216,097		216,097	0	216,097	56.00
57.00	05700	CT SCAN	720,504		720,504	0	720,504	57.00
58.00	05800	MRI	444,186		444,186	0	444,186	58.00
60.00	06000	LABORATORY	6,270,269		6,270,269	0	6,270,269	60.00
65.00	06500	RESPIRATORY THERAPY	1,165,708	0	1,165,708	0	1,165,708	65.00
66.00	06600	PHYSICAL THERAPY	1,222,524	0	1,222,524	0	1,222,524	66.00
67.00	06700	OCCUPATIONAL THERAPY	540,946	0	540,946	0	540,946	67.00
68.00	06800	SPEECH PATHOLOGY	126,036	0	126,036	0	126,036	68.00
69.00	06900	ELECTROCARDIOLOGY	1,303,758		1,303,758	0	1,303,758	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	444,279		444,279	0	444,279	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	431,746		431,746	0	431,746	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,839,391		13,839,391	0	13,839,391	73.00
76.97	07697	CARDIAC REHABILITATION	191,426		191,426	0	191,426	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,071,366		2,071,366	0	2,071,366	90.00
90.01	09001	CLINIC - DIABETES	208,118		208,118	0	208,118	90.01
91.00	09100	EMERGENCY	5,260,691		5,260,691	0	5,260,691	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,210,107		2,210,107		2,210,107	92.00
200.00		Subtotal (see instructions)	51,212,121	0	51,212,121	0	51,212,121	200.00
201.00		Less Observation Beds	2,210,107		2,210,107		2,210,107	201.00
202.00		Total (see instructions)	49,002,014	0	49,002,014	0	49,002,014	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 12:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,236,639		5,236,639			30.00
31.00	03100	INTENSIVE CARE UNIT	5,993,812		5,993,812			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,343,843	21,738,752	24,082,595	0.111651	0.000000	50.00
51.00	05100	RECOVERY ROOM	286,404	3,102,184	3,388,588	0.183411	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	609,334	12,363,752	12,973,086	0.173132	0.000000	54.00
56.00	05600	RADIOISOTOPE	222,802	2,186,704	2,409,506	0.089685	0.000000	56.00
57.00	05700	CT SCAN	552,797	6,615,776	7,168,573	0.100509	0.000000	57.00
58.00	05800	MRI	184,252	2,418,227	2,602,479	0.170678	0.000000	58.00
60.00	06000	LABORATORY	2,815,029	16,566,967	19,381,996	0.323510	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,083,207	2,974,033	4,057,240	0.287316	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	295,293	2,641,406	2,936,699	0.416292	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	151,936	883,686	1,035,622	0.522339	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	40,850	327,221	368,071	0.342423	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	769,218	9,840,591	10,609,809	0.122882	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	473,450	1,621,026	2,094,476	0.212119	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	124,035	1,657,646	1,781,681	0.242325	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,107,499	45,575,965	50,683,464	0.273055	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	539	1,156,107	1,156,646	0.165501	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	56	10,682,890	10,682,946	0.193895	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	75,648	75,648	2.751137	0.000000	90.01
91.00	09100	EMERGENCY	1,092,434	30,980,120	32,072,554	0.164025	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	63,102	11,161,030	11,224,132	0.196907	0.000000	92.00
200.00		Subtotal (see instructions)	27,446,531	184,569,731	212,016,262			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	27,446,531	184,569,731	212,016,262			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 12:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	212,608	24,082,595	0.008828	940,307	8,301	50.00
51.00	05100	RECOVERY ROOM	7,800	3,388,588	0.002302	113,186	261	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,612	12,973,086	0.006753	298,989	2,019	54.00
56.00	05600	RADIOISOTOPE	1,712	2,409,506	0.000711	111,144	79	56.00
57.00	05700	CT SCAN	22,505	7,168,573	0.003139	168,232	528	57.00
58.00	05800	MRI	19,262	2,602,479	0.007401	90,386	669	58.00
60.00	06000	LABORATORY	121,754	19,381,996	0.006282	1,380,840	8,674	60.00
65.00	06500	RESPIRATORY THERAPY	33,222	4,057,240	0.008188	650,644	5,327	65.00
66.00	06600	PHYSICAL THERAPY	53,197	2,936,699	0.018115	196,181	3,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,930	1,035,622	0.018279	98,335	1,797	67.00
68.00	06800	SPEECH PATHOLOGY	6,284	368,071	0.017073	31,231	533	68.00
69.00	06900	ELECTROCARDIOLOGY	65,720	10,609,809	0.006194	447,863	2,774	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,799	2,094,476	0.005156	236,017	1,217	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,495	1,781,681	0.005891	28,500	168	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,209	50,683,464	0.002155	2,544,618	5,484	73.00
76.97	07697	CARDIAC REHABILITATION	29,525	1,156,646	0.025526	153	4	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	115,003	10,682,946	0.010765	0	0	90.00
90.01	09001	CLINIC - DIABETES	9,242	75,648	0.122171	0	0	90.01
91.00	09100	EMERGENCY	138,682	32,072,554	0.004324	62,297	269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	91,090	11,224,132	0.008116	3,570	29	92.00
200.00		Total (lines 50 through 199)	1,164,651	200,785,811		7,402,493	41,687	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328

Period: From 01/01/2018 To 12/31/2018

Worksheet D Part IV
Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	24,082,595	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,388,588	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,973,086	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	2,409,506	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	7,168,573	0.000000	57.00
58.00	05800	MRI	0	0	0	2,602,479	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	19,381,996	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,057,240	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,936,699	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,035,622	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	368,071	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,609,809	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,094,476	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,781,681	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	50,683,464	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,156,646	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	10,682,946	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	75,648	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	32,072,554	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	11,224,132	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	200,785,811		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	940,307	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	113,186	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	298,989	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	111,144	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	168,232	0	0	0	57.00
58.00	05800	MRI	0.000000	90,386	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,380,840	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	650,644	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	196,181	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	98,335	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	31,231	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	447,863	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	236,017	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	28,500	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,544,618	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	153	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	62,297	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3,570	0	0	0	92.00
200.00		Total (lines 50 through 199)		7,402,493	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.111651	0	6,202,223	0	0	50.00
51.00	05100	RECOVERY ROOM	0.183411	0	844,440	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173132	0	3,307,080	0	0	54.00
56.00	05600	RADIOISOTOPE	0.089685	0	987,620	0	0	56.00
57.00	05700	CT SCAN	0.100509	0	2,657,823	0	0	57.00
58.00	05800	MRI	0.170678	0	849,506	0	0	58.00
60.00	06000	LABORATORY	0.323510	0	5,595,479	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.287316	0	1,148,713	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.416292	0	923,003	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.522339	0	282,434	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.342423	0	38,671	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.122882	0	3,164,974	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.212119	0	391,197	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.242325	0	361,631	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.273055	0	20,412,684	10,068	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.165501	0	534,873	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.193895	0	4,770,050	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.751137	0	13,712	0	0	90.01
91.00	09100	EMERGENCY	0.164025	0	9,849,317	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.196907	0	5,691,433	0	0	92.00
200.00		Subtotal (see instructions)		0	68,026,863	10,068	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	68,026,863	10,068	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	692,484	0	50.00
51.00	05100	RECOVERY ROOM	154,880	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	572,561	0	54.00
56.00	05600	RADIOISOTOPE	88,575	0	56.00
57.00	05700	CT SCAN	267,135	0	57.00
58.00	05800	MRI	144,992	0	58.00
60.00	06000	LABORATORY	1,810,193	0	60.00
65.00	06500	RESPIRATORY THERAPY	330,044	0	65.00
66.00	06600	PHYSICAL THERAPY	384,239	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	147,526	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,242	0	68.00
69.00	06900	ELECTROCARDIOLOGY	388,918	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	82,980	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87,632	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,573,785	2,749	73.00
76.97	07697	CARDIAC REHABILITATION	88,522	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	924,889	0	90.00
90.01	09001	CLINIC - DIABETES	37,724	0	90.01
91.00	09100	EMERGENCY	1,615,534	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,120,683	0	92.00
200.00		Subtotal (see instructions)	14,526,538	2,749	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	14,526,538	2,749	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1328 | Component CCN: 15-Z328

Period: From 01/01/2018 To 12/31/2018

Worksheet D Part V

Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.111651	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.183411	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173132	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.089685	0	0	0	0	56.00
57.00	05700	CT SCAN	0.100509	0	0	0	0	57.00
58.00	05800	MRI	0.170678	0	0	0	0	58.00
60.00	06000	LABORATORY	0.323510	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.287316	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.416292	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.522339	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.342423	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.122882	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.212119	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.242325	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.273055	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.165501	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.193895	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.751137	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.164025	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.196907	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 12:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.111651	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.183411	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173132	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.089685	0	0	0	0	56.00
57.00	05700	CT SCAN	0.100509	0	0	0	0	57.00
58.00	05800	MRI	0.170678	0	0	0	0	58.00
60.00	06000	LABORATORY	0.323510	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.287316	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.416292	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.522339	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.342423	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.122882	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.212119	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.242325	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.273055	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.165501	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.193895	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.751137	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.164025	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.196907	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 12:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,456	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,420	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)	2,906	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	18	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	18	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)	1,656	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)	18	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,480,815	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)	2,325	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)	28,601	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,452,214	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)	6,452,214	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,459.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,417,396	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)	2,417,396	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,507,748	900	2,786.39	460	1,281,739	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,814,969	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,514,104	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)	26,276	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)	26,276	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)	1,514	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,459.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,210,107	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1328	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 12:16 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	267,106	6,480,815	0.041215	2,210,107	91,090	90.00
91.00	Nursing School cost	0	6,480,815	0.000000	2,210,107	0	91.00
92.00	Allied health cost	0	6,480,815	0.000000	2,210,107	0	92.00
93.00	All other Medical Education	0	6,480,815	0.000000	2,210,107	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:16 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)	4,456	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,420	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)	2,906	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	18	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	18	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)	53	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,480,815	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)	2,325	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)	28,601	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,452,214	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)	6,452,214	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,459.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	77,368	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)	77,368	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:16 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	2,507,748	900	2,786.39	17	47,369	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)	79,528	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	204,265	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)	1,514	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,459.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,210,107	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:16 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	267,106	6,480,815	0.041215	2,210,107	91,090	90.00
91.00	Nursing School cost	0	6,480,815	0.000000	2,210,107	0	91.00
92.00	Allied health cost	0	6,480,815	0.000000	2,210,107	0	92.00
93.00	All other Medical Education	0	6,480,815	0.000000	2,210,107	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,972,228		30.00
31.00	03100	INTENSIVE CARE UNIT		2,758,629		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111651	940,307	104,986	50.00
51.00	05100	RECOVERY ROOM	0.183411	113,186	20,760	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173132	298,989	51,765	54.00
56.00	05600	RADIOISOTOPE	0.089685	111,144	9,968	56.00
57.00	05700	CT SCAN	0.100509	168,232	16,909	57.00
58.00	05800	MRI	0.170678	90,386	15,427	58.00
60.00	06000	LABORATORY	0.323510	1,380,840	446,716	60.00
65.00	06500	RESPIRATORY THERAPY	0.287316	650,644	186,940	65.00
66.00	06600	PHYSICAL THERAPY	0.416292	196,181	81,669	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.522339	98,335	51,364	67.00
68.00	06800	SPEECH PATHOLOGY	0.342423	31,231	10,694	68.00
69.00	06900	ELECTROCARDIOLOGY	0.122882	447,863	55,034	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.212119	236,017	50,064	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.242325	28,500	6,906	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.273055	2,544,618	694,821	73.00
76.97	07697	CARDIAC REHABILITATION	0.165501	153	25	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.193895	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.751137	0	0	90.01
91.00	09100	EMERGENCY	0.164025	62,297	10,218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.196907	3,570	703	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,402,493	1,814,969	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)		7,402,493		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3

Component CCN: 15-Z328 | Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111651	0	0	50.00
51.00	05100	RECOVERY ROOM	0.183411	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173132	0	0	54.00
56.00	05600	RADIOISOTOPE	0.089685	0	0	56.00
57.00	05700	CT SCAN	0.100509	0	0	57.00
58.00	05800	MRI	0.170678	0	0	58.00
60.00	06000	LABORATORY	0.323510	6,109	1,976	60.00
65.00	06500	RESPIRATORY THERAPY	0.287316	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.416292	5,343	2,224	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.522339	2,749	1,436	67.00
68.00	06800	SPEECH PATHOLOGY	0.342423	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.122882	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.212119	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.242325	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.273055	11,811	3,225	73.00
76.97	07697	CARDIAC REHABILITATION	0.165501	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.193895	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.751137	0	0	90.01
91.00	09100	EMERGENCY	0.164025	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.196907	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		26,012	8,861	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)		26,012		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 Date/Time Prepared: 5/28/2019 12:16 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		91,923		30.00
31.00	03100	INTENSIVE CARE UNIT		95,675		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111651	0	0	50.00
51.00	05100	RECOVERY ROOM	0.183411	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173132	12,707	2,200	54.00
56.00	05600	RADIOISOTOPE	0.089685	3,422	307	56.00
57.00	05700	CT SCAN	0.100509	30,135	3,029	57.00
58.00	05800	MRI	0.170678	0	0	58.00
60.00	06000	LABORATORY	0.323510	53,342	17,257	60.00
65.00	06500	RESPIRATORY THERAPY	0.287316	32,988	9,478	65.00
66.00	06600	PHYSICAL THERAPY	0.416292	3,344	1,392	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.522339	2,599	1,358	67.00
68.00	06800	SPEECH PATHOLOGY	0.342423	638	218	68.00
69.00	06900	ELECTROCARDIOLOGY	0.122882	6,262	769	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.212119	3,237	687	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.242325	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.273055	110,531	30,181	73.00
76.97	07697	CARDIAC REHABILITATION	0.165501	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.193895	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.751137	0	0	90.01
91.00	09100	EMERGENCY	0.164025	72,850	11,949	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.196907	3,570	703	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		335,625	79,528	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)		335,625		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 12:16 pm

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111651	0	0	50.00
51.00	05100	RECOVERY ROOM	0.183411	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173132	0	0	54.00
56.00	05600	RADIOISOTOPE	0.089685	0	0	56.00
57.00	05700	CT SCAN	0.100509	0	0	57.00
58.00	05800	MRI	0.170678	0	0	58.00
60.00	06000	LABORATORY	0.323510	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.287316	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.416292	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.522339	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.342423	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.122882	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.212119	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.242325	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.273055	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.165501	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.193895	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.751137	0	0	90.01
91.00	09100	EMERGENCY	0.164025	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.196907	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part B Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	14,529,287	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	14,529,287	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)	14,674,580	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	88,173	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	12,433,159	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,153,248	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,153,248	30.00
31.00	Primary payer payments	319	31.00
32.00	Subtotal (line 30 minus line 31)	2,152,929	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)	1,554,980	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	1,010,737	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,128,244	36.00
37.00	Subtotal (see instructions)	3,163,666	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)	3,163,666	40.00
40.01	Sequestration adjustment (see instructions)	63,273	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,502,429	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-402,036	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	636,642	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: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,800,431		3,502,429	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)		4,800,431		3,502,429	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		145,096		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		402,036	6.02
7.00	Total Medicare program liability (see instructions)		4,945,527		3,100,393	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		37,220		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		37,220		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		418		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		37,638		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1328	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/28/2019 12:16 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	26,539	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	8,950	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	18	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	35,489	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	35,489	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	35,489	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	35,489	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	4,487	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	2,917	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	38,406	0	19.00
19.01	Sequestration adjustment (see instructions)	768	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	37,220	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	418	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	1,544	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 5/28/2019 12:16 pm

Title XIX | Swing Beds - SNF | Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-3 Part V | Date/Time Prepared: 5/28/2019 12:16 pm

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,514,104	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	5,514,104	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,569,245	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,569,245	19.00
20.00	Deductibles (exclude professional component)	560,024	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,009,221	22.00
23.00	Coinsurance	5,348	23.00
24.00	Subtotal (line 22 minus line 23)	5,003,873	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	65,513	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	42,583	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	47,002	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,046,456	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	5,046,456	30.00
30.01	Sequestration adjustment (see instructions)	100,929	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	4,800,431	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	145,096	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	242,254	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)	Provider CCN: 15-1328	Period: From 01/01/2018 To 12/31/2018	Worksheet G Date/Time Prepared: 5/28/2019 12:16 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	38,934,774	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	9,356,527	0	0	0	4.00
5.00	Other receivable	-2,315,436	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,101,380	0	0	0	7.00
8.00	Prepaid expenses	221,074	0	0	0	8.00
9.00	Other current assets	72,103	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	47,370,422	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	931,334	0	0	0	12.00
13.00	Land improvements	1,119,735	0	0	0	13.00
14.00	Accumulated depreciation	-1,049,586	0	0	0	14.00
15.00	Buildings	20,143,774	0	0	0	15.00
16.00	Accumulated depreciation	-13,039,737	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	200,961	0	0	0	21.00
22.00	Accumulated depreciation	-189,321	0	0	0	22.00
23.00	Major movable equipment	15,049,914	0	0	0	23.00
24.00	Accumulated depreciation	-11,681,031	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	1,532,587	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,018,630	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,851,842	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,851,842	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	64,240,894	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,141,685	0	0	0	37.00
38.00	Salaries, wages, and fees payable	530,409	0	0	0	38.00
39.00	Payroll taxes payable	922,891	0	0	0	39.00
40.00	Notes and loans payable (short term)	74,336	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,930,294	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,599,615	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	142,101	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	142,101	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,741,716	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	56,499,178				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)	56,499,178	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	64,240,894	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/28/2019 12:16 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		50,418,408		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,393,937				2.00
3.00	Total (sum of line 1 and line 2)		61,812,345		0		3.00
4.00	RESTRICTED FUND BALANCE	77,000		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)		77,000		0		10.00
11.00	Subtotal (line 3 plus line 10)		61,889,345		0		11.00
12.00	INTERCOMPANY CAPITAL TRANSFER	5,390,165		0		0	12.00
13.00	ROUNDING	2		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)		5,390,167		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		56,499,178		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	RESTRICTED FUND BALANCE		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	INTERCOMPANY CAPITAL TRANSFER		0		12.00
13.00	ROUNDING		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: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/28/2019 12:16 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,207,406		5,207,406	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	29,232		29,232	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,236,638		5,236,638	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,993,813		5,993,813	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)	5,993,813		5,993,813	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,230,451		11,230,451	17.00
18.00	Ancillary services	16,152,978	173,408,701	189,561,679	18.00
19.00	Outpatient services	63,102	11,161,030	11,224,132	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	1,717,917	1,717,917	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	27,446,531	186,287,648	213,734,179	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		55,473,174		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)		55,473,174		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/28/2019 12:16 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	213,734,179	1.00
2.00	Less contractual allowances and discounts on patients' accounts	148,483,461	2.00
3.00	Net patient revenues (line 1 minus line 2)	65,250,718	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	55,473,174	4.00
5.00	Net income from service to patients (line 3 minus line 4)	9,777,544	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	1,616,393	24.00
25.00	Total other income (sum of lines 6-24)	1,616,393	25.00
26.00	Total (line 5 plus line 25)	11,393,937	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)	11,393,937	29.00