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: 15-1311	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 12:43 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2019 Time: 12:43 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 IU HEALTH TIPTON HOSPITAL (15-1311) 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) CARA BREIDSTER
Officer or Administrator of Provider(s)

CFO
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	139,710	949,369	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	-7,493	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	132,217	949,369	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: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 12:43 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 SOUTH MAIN STREET	PO Box:			1.00
2.00	City: TIPTON	State: IN	Zip Code: 46072	County: TIPTON	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	IU HEALTH TIPTON HOSPITAL	151311	99915	1	11/12/2005	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 TIPTON HOSPITAL	15Z311	29020		11/12/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	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	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: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 12:43 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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 12:43 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 12:43 pm

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

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

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

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

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				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.	Y	N	N	Y	109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 12:43 pm

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	58,039	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: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 12:43 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	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	12	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2019 12:43 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/28/2019	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			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: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 12:43 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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.			Y		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: 15-1311	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 12:43 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 OF GOVERNMENT PROGRAMS		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: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 12:43 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	25	9,125	58,656.00	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)		25	9,125	58,656.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	58,656.00	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: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 12:43 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)	1,441	0	2,444			1.00
2.00	HMO and other (see instructions)	361	157				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	375	0	375			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	43			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,816	0	2,862			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,816	0	2,862	0.00	176.55	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	176.55	27.00
28.00	Observation Bed Days		1	619			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: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 12:43 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	397	0	702	1.00
2.00	HMO and other (see instructions)			88	34		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	397	0	702	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: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/29/2019 12:43 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)	0.315773	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	706,496	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	10,016,598	6.00
7.00	Medicaid cost (line 1 times line 6)	3,162,971	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)	2,456,475	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)	2,456,475	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)	1,579,483	72,846	1,652,329	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	498,758	72,846	571,604	21.00
22.00	Payments received from patients for amounts previously written off as charity care	7,574	7,220	14,794	22.00
23.00	Cost of charity care (line 21 minus line 22)	491,184	65,626	556,810	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)	2,003,957	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	365,103	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	561,697	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,442,260	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	652,021	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,208,831	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,665,306	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 12:43 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	784,821	784,821	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES		0	0	742,787	742,787	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,156,572	1,156,572	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	88,952	38,330	127,282	1,878,400	2,005,682	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	863,995	8,068,784	8,932,779	-1,721,213	7,211,566	5.00
7.00	00700	OPERATION OF PLANT	766,614	3,480,449	4,247,063	-96,309	4,150,754	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	62,364	62,364	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	51,210	85,114	136,324	-24,906	111,418	8.00
9.00	00900	HOUSEKEEPING	332,863	217,220	550,083	-150,833	399,250	9.00
10.00	01000	DIETARY	463,926	421,364	885,290	-640,826	244,464	10.00
11.00	01100	CAFETERIA	0	0	0	515,222	515,222	11.00
13.00	01300	NURSING ADMINISTRATION	488,104	147,128	635,232	25,059	660,291	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,144	11,144	871,517	882,661	14.00
15.00	01500	PHARMACY	594,628	2,260,050	2,854,678	-1,695,595	1,159,083	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,955,998	1,273,312	3,229,310	-553,555	2,675,755	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,046,730	3,148,816	4,195,546	-2,601,704	1,593,842	50.00
53.00	05300	ANESTHESIOLOGY	179,226	344,173	523,399	-32,288	491,111	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,078,157	1,124,461	2,202,618	-910,096	1,292,522	54.00
60.00	06000	LABORATORY	0	1,245,886	1,245,886	0	1,245,886	60.00
65.00	06500	RESPIRATORY THERAPY	467,758	182,356	650,114	-115,531	534,583	65.00
66.00	06600	PHYSICAL THERAPY	656,335	392,945	1,049,280	-370,452	678,828	66.00
67.00	06700	OCCUPATIONAL THERAPY	166,082	41,925	208,007	17,366	225,373	67.00
69.00	06900	ELECTROCARDIOLOGY	425,354	158,252	583,606	-85,865	497,741	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	292,896	292,896	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,506,110	1,506,110	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,706,703	1,706,703	73.00
73.01	03480	ONCOLOGY	193,937	80,286	274,223	-44,932	229,291	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	105,367	55,971	161,338	-27,753	133,585	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,130,125	1,792,587	2,922,712	-262,496	2,660,216	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)	11,055,361	24,570,553	35,625,914	225,463	35,851,377	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	146,821	222,362	369,183	-201,273	167,910	192.00
192.01	19201	OCCUPATIONAL MEDICINE	36,121	77,708	113,829	-24,190	89,639	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	11,238,303	24,870,623	36,108,926	0	36,108,926	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 12:43 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	827,009	1,611,830		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	-90,948	651,839		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	170,390	1,326,962		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	125,064	2,130,746		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-994,425	6,217,141		5.00
7.00	00700	OPERATION OF PLANT	-247	4,150,507		7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	-47,625	14,739		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	111,418		8.00
9.00	00900	HOUSEKEEPING	-27,381	371,869		9.00
10.00	01000	DIETARY	0	244,464		10.00
11.00	01100	CAFETERIA	-142,925	372,297		11.00
13.00	01300	NURSING ADMINISTRATION	-29,571	630,720		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-434	882,227		14.00
15.00	01500	PHARMACY	-409,493	749,590		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-527,079	2,148,676		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-319,084	1,274,758		50.00
53.00	05300	ANESTHESIOLOGY	-429,472	61,639		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-63,800	1,228,722		54.00
60.00	06000	LABORATORY	0	1,245,886		60.00
65.00	06500	RESPIRATORY THERAPY	-498	534,085		65.00
66.00	06600	PHYSICAL THERAPY	-298	678,530		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	225,373		67.00
69.00	06900	ELECTROCARDIOLOGY	-58,605	439,136		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	292,896		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,506,110		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,706,703		73.00
73.01	03480	ONCOLOGY	0	229,291		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	133,585		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-957,634	1,702,582		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)	-2,977,056	32,874,321		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	167,910		192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	89,639		192.01
192.02	19202	VACANT SPACE	0	0		192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,977,056	33,131,870		200.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 12:43 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	540,364	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,154,951	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
	TOTALS		0	1,695,315	
	B - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	0	742,787	1.00
	TOTALS		0	742,787	
	C - OTHER CAPITAL				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,795	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	48,822	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,621	3.00
	TOTALS		0	58,238	
	D - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,878,383	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
	TOTALS		0	1,878,383	
	E - CAFETERIA				
1.00	CAFETERIA	11.00	314,637	200,585	1.00
	TOTALS		314,637	200,585	
	F - MEDICAL SUPPLIES				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	17	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	160	2.00
3.00	NURSING ADMINISTRATION	13.00	0	54	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	871,163	4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	292,896	5.00
6.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,506,110	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
	TOTALS		0	2,670,400	

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 12:43 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	G - DRUGS				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	597	1.00
2.00	PHARMACY	15.00	0	445,790	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,706,703	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
	TOTALS		0	2,153,090	
	H - ORTHOPEDIC CLERICAL STAFF				
1.00	OCCUPATIONAL THERAPY	67.00	47,882	0	1.00
	TOTALS		47,882	0	
	I - VP OF NURSING				
1.00	NURSING ADMINISTRATION	13.00	94,899	0	1.00
	TOTALS		94,899	0	
	J - SURGERY ON-CALL				
1.00	OPERATING ROOM	50.00		65,271	1.00
	TOTALS		0	65,271	
	K - MAINTENANCE & LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	203,430	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,027	2.00
3.00	OPERATION OF PLANT	7.00	0	7,510	3.00
4.00	OPERATION OF PLANT - OFFSITE	7.01	0	62,364	4.00
	TOTALS		0	274,331	
500.00	Grand Total: Increases		457,418	9,738,400	500.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 12:43 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	756,127	9		1.00
2.00	OPERATION OF PLANT	7.00	0	61,342	9		2.00
3.00	DIETARY	10.00	0	5,900	0		3.00
4.00	PHARMACY	15.00	0	39,498	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	442	0		5.00
6.00	OPERATING ROOM	50.00	0	78,354	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	12,407	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	640,261	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	44,072	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	3,798	0		10.00
11.00	CARDIAC REHABILITATION	76.97	0	10,919	0		11.00
12.00	EMERGENCY	91.00	0	13,732	0		12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	28,463	0		13.00
	TOTALS		0	1,695,315			
	B - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	742,787	11		1.00
	TOTALS		0	742,787			
	C - OTHER CAPITAL						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,795	13		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	48,822	12		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	1,621	12		3.00
	TOTALS		0	58,238			
	D - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	85,939	0		1.00
2.00	OPERATION OF PLANT	7.00	0	33,554	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	24,906	0		3.00
4.00	HOUSEKEEPING	9.00	0	132,529	0		4.00
5.00	DIETARY	10.00	0	119,645	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	69,894	0		6.00
7.00	PHARMACY	15.00	0	82,159	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	371,872	0		8.00
9.00	OPERATING ROOM	50.00	0	198,747	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	7,554	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	195,076	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	84,138	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	124,626	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	30,212	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	57,746	0		15.00
16.00	ONCOLOGY	73.01	0	33,401	0		16.00
17.00	CARDIAC REHABILITATION	76.97	0	15,946	0		17.00
18.00	EMERGENCY	91.00	0	169,022	0		18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	28,268	0		19.00
20.00	OCCUPATIONAL MEDICINE	192.01	0	13,149	0		20.00
	TOTALS		0	1,878,383			
	E - CAFETERIA						
1.00	DIETARY	10.00	314,637	200,585	0		1.00
	TOTALS		314,637	200,585			
	F - MEDICAL SUPPLIES						
1.00	OPERATION OF PLANT	7.00	0	8,923	0		1.00
2.00	HOUSEKEEPING	9.00	0	18,304	0		2.00
3.00	DIETARY	10.00	0	54	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	243	0		4.00
5.00	PHARMACY	15.00	0	5,300	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	99,420	0		6.00
7.00	OPERATING ROOM	50.00	0	2,373,136	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	765	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	24,442	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	31,212	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	17,108	0		11.00
12.00	OCCUPATIONAL THERAPY	67.00	0	304	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	12,590	0		13.00
14.00	ONCOLOGY	73.01	0	9,371	0		14.00
15.00	CARDIAC REHABILITATION	76.97	0	888	0		15.00
16.00	EMERGENCY	91.00	0	59,341	0		16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6,608	0		17.00
18.00	OCCUPATIONAL MEDICINE	192.01	0	2,391	0		18.00
	TOTALS		0	2,670,400			
	G - DRUGS						
1.00	DIETARY	10.00	0	5	0		1.00
2.00	PHARMACY	15.00	0	2,014,428	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	16,550	0		3.00
4.00	OPERATING ROOM	50.00	0	16,738	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	11,562	0		5.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 12:43 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	50,317	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	181	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	303	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	11,731	0		9.00
10.00	ONCOLOGY	73.01	0	2,160	0		10.00
11.00	EMERGENCY	91.00	0	20,401	0		11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	64	0		12.00
13.00	OCCUPATIONAL MEDICINE	192.01	0	8,650	0		13.00
	TOTALS		0	2,153,090			
	H - ORTHOPEDIC CLERICAL STAFF						
1.00	PHYSICAL THERAPY	66.00	47,882	0	0		1.00
	TOTALS		47,882	0			
	I - VP OF NURSING						
1.00	ADMINISTRATIVE & GENERAL	5.00	94,899	0	0		1.00
	TOTALS		94,899	0			
	J - SURGERY ON-CALL						
1.00	ADULTS & PEDIATRICS	30.00		65,271	0		1.00
	TOTALS		0	65,271			
	K - MAINTENANCE & LEASE EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	136,461	10		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	137,870	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	274,331			
500.00	Grand Total: Decreases		457,418	9,738,400			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2019 12:43 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	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	2,098,521	773,936	0	773,936	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	10,180,402	2,270,564	0	2,270,564	891,396	6.00
7.00	HIT designated Assets	964,363	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,243,286	3,044,500	0	3,044,500	891,396	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	13,243,286	3,044,500	0	3,044,500	891,396	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	2,872,457	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	11,559,570	0	6.00
7.00	HIT designated Assets	964,363	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,396,390	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	15,396,390	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2019 12:43 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
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	0	0	1.01
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
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	1.01
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: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III | Date/Time Prepared: 5/29/2019 12:43 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: 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	3,836,820	0	3,836,820	0.249203	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	11,559,569	0	11,559,569	0.750797	0	2.00
3.00	Total (sum of lines 1-2)	15,396,389	0	15,396,389	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: 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	1,402,337	168,466	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	418,982	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,325,341	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,146,660	168,466	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	48,822	-7,795	0	1,611,830	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	232,857	0	0	0	651,839	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,621	0	0	1,326,962	2.00
3.00	Total (sum of lines 1-2)	232,857	50,443	-7,795	0	3,590,631	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 12:43 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - INTERES (chapter 2)	B	-509,930	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	11	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-2,141,846			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2,865,423			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-143,060	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-417,390	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		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	-498	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	855,830	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - INTERES		0	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	98,044	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 12:43 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-57,676	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-6,296	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-49,057	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	INVESTMENT FEES	A	8,973	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	150	OPERATION OF PLANT	7.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-246	ANESTHESIOLOGY	53.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-27,381	HOUSEKEEPING	9.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	135	CAFETERIA	11.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-483	NURSING ADMINISTRATION	13.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-63	RADIOLOGY-DIAGNOSTIC	54.00	0	33.08
33.11	MISCELLANEOUS INCOME	B	-32,589	ELECTROCARDIOLOGY	69.00	0	33.11
33.12	MEDICAID HOSPITAL ASSESSMENT FEE	B	-1,043,581	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	ASSISTED LIVING DEPRECIATION - BLDG	A	-131,829	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
33.14	ASSISTED LIVING DEPRECIATION - MVBLE	A	-807	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.14
33.15	CRNA SALARY EXPENSE	A	-179,226	ANESTHESIOLOGY	53.00	0	33.15
33.16	CRNA BENEFITS EXPENSE	A	-35,661	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	PATIENT PHONES - SALARY	A	-2,366	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	PATIENT PHONES - BENEFITS	A	-471	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	EMPLOYEE BENEFITS	A	-1,878,427	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.20	CABLE	A	-397	OPERATION OF PLANT	7.00	0	33.20
33.21	CABLE	A	-298	PHYSICAL THERAPY	66.00	0	33.21
33.22	ACCURED PTO	A	-83,000	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.22
33.23	LEASE DEPRECIATION - CARRY FORWARD A	A	284	CAP REL COSTS-BLDG & FIXT	1.00	9	33.23
33.24	EQUIPMENT DEPRECIATION - CARRY FORWA	A	15,476	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.24
33.25	LEASE REVENUE	B	-34,964	CAP REL COSTS-BLDG & FIXT	1.00	10	33.25
33.28	MISCELLANEOUS INCOME	B	7,897	PHARMACY	15.00	0	33.28
33.29	TELEPHONE EQUIPMENT	A	-434	CENTRAL SERVICES & SUPPLY	14.00	0	33.29
33.30	TELEPHONE EQUIPMENT	A	-893	EMERGENCY	91.00	0	33.30
33.31	UNWONTED SITUATIONS	A	-120	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	MARKETING	A	-49,468	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	MARKETING	A	-192	ADULTS & PEDIATRICS	30.00	0	33.33
33.34	MARKETING	A	-32	RADIOLOGY-DIAGNOSTIC	54.00	0	33.34
33.35	MARKETING	A	-16	ELECTROCARDIOLOGY	69.00	0	33.35
33.36	MARKETING	A	-571	EMERGENCY	91.00	0	33.36
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,977,056				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: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2019 12:43 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 ALLOCATION	261,358	123,670	1.00
2.00	1.01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOCATION	1,161,769	742,787	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	115,353	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	2,134,871	5,952	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	5,517,605	5,376,411	4.01
4.02	7.00	OPERATION OF PLANT	INTERCOMPANY	654,477	654,477	4.02
4.03	7.01	OPERATION OF PLANT - OFFSITE	INTERCOMPANY	0	47,625	4.03
4.04	13.00	NURSING ADMINISTRATION	INTERCOMPANY	54,857	83,945	4.04
4.05	30.00	ADULTS & PEDIATRICS	INTERCOMPANY	526,887	526,887	4.05
4.06	50.00	OPERATING ROOM	INTERCOMPANY	37,137	37,137	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	INTERCOMPANY	77,590	77,590	4.07
4.08	60.00	LABORATORY	INTERCOMPANY	1,216,091	1,216,091	4.08
4.09	69.00	ELECTROCARDIOLOGY	INTERCOMPANY	193,970	193,970	4.09
4.10	73.01	ONCOLOGY	INTERCOMPANY	12,671	12,671	4.10
4.11	91.00	EMERGENCY	INTERCOMPANY	1,460,026	1,460,026	4.11
4.12	192.01	OCCUPATIONAL MEDICINE	INTERCOMPANY	28,441	28,441	4.12
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			13,453,103	10,587,680	5.00

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

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

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

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

6.00	B		0.00	IU HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1311	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/29/2019 12:43 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	137,688	9		1.00
2.00	418,982	9		2.00
3.00	115,353	9		3.00
4.00	2,128,919	0		4.00
4.01	141,194	0		4.01
4.02	0	0		4.02
4.03	-47,625	0		4.03
4.04	-29,088	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	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
5.00	2,865,423			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	HEALTHCARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2019 12:43 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	30.00	ADULTS & PEDIATRICS	526,887	526,887	0	0	0	1.00
2.00	50.00	OPERATING ROOM	319,084	319,084	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	250,000	250,000	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	63,705	63,705	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	26,000	26,000	0	0	0	5.00
6.00	91.00	EMERGENCY	1,430,703	956,170	474,533	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			2,616,379	2,141,846	474,533		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	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	30.00	ADULTS & PEDIATRICS	0	0	0	526,887		1.00
2.00	50.00	OPERATING ROOM	0	0	0	319,084		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	250,000		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	63,705		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	26,000		5.00
6.00	91.00	EMERGENCY	0	0	0	956,170		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	2,141,846		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2019 12:43 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					8	1.00
2.00	Line 1 multiplied by 15 hours per week					120	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					9	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.45	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	0.00	49.75	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	82.91	62.18	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.46	41.46	31.09			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					0	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					3,093	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					3,093	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					3,093	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					62.17	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					7,460	22.00
23.00	Total salary equivalency (see instructions)					7,460	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					373	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					373	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					49	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					422	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					422	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2019 12:43 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	82.91	62.18	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	7,460		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	422		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	7,882		63.00
64.00	Total cost of outside supplier services (from your records)	1,688		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	373		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	49		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	422		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	49		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	49		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1311	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2019 12:43 pm

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		19	1.00
2.00	Line 1 multiplied by 15 hours per week		285	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		43	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.45	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	517.42	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	65.18	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	32.59	32.59	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	33,725	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	33,725	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	33,725	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	33,725	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	1,401	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	1,401	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	234	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	1,635	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	1,635	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1311	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2019 12:43 pm

		Respiratory Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	16.00	0.00	0.00	0.00	16.00	47.00
48.00	Overtime rate (see instructions)	97.77	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	1,564.32	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100.00	0.00	0.00	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2,080.00	0.00	0.00	0.00	2,080.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	65.18	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	135,574	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	1,564	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	1,043	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	521	0	0	0	521	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		33,725	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		1,635	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		521	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		35,881	63.00
64.00	Total cost of outside supplier services (from your records)		36,379	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		498	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		1,401	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		234	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		1,635	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		234	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		234	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 12:43 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,611,830	1,611,830				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	651,839	0	651,839			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,326,962			1,326,962		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,130,746	7,149	3,261	5,902	2,147,058	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,217,141	111,628	50,920	92,153	150,527	5.00
7.00	00700	OPERATION OF PLANT	4,150,507	395,480	158,582	326,485	150,041	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	14,739	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	111,418	26,716	12,187	22,055	10,023	8.00
9.00	00900	HOUSEKEEPING	371,869	15,930	7,267	13,151	65,148	9.00
10.00	01000	DIETARY	244,464	22,197	10,125	18,324	29,219	10.00
11.00	01100	CAFETERIA	372,297	46,777	21,338	38,616	61,580	11.00
13.00	01300	NURSING ADMINISTRATION	630,720	36,404	16,606	30,053	114,105	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	882,227	34,458	15,718	28,446	0	14.00
15.00	01500	PHARMACY	749,590	12,418	5,665	10,251	116,380	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,148,676	160,128	73,044	132,192	382,820	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,274,758	201,876	92,088	166,656	204,865	50.00
53.00	05300	ANESTHESIOLOGY	61,639	3,809	1,738	3,145	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,228,722	104,100	47,486	85,938	211,016	54.00
60.00	06000	LABORATORY	1,245,886	40,700	18,566	33,599	0	60.00
65.00	06500	RESPIRATORY THERAPY	534,085	2,457	1,121	2,028	91,549	65.00
66.00	06600	PHYSICAL THERAPY	678,530	51,939	6,349	42,877	119,086	66.00
67.00	06700	OCCUPATIONAL THERAPY	225,373	16,029	1,937	13,233	41,877	67.00
69.00	06900	ELECTROCARDIOLOGY	439,136	27,334	12,469	22,565	83,250	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	292,896	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,506,110	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,706,703	0	0	0	0	73.00
73.01	03480	ONCOLOGY	229,291	16,310	7,440	13,464	37,957	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	133,585	19,204	8,760	15,853	20,622	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,702,582	115,240	52,568	95,135	221,187	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)	32,874,321	1,468,283	625,235	1,212,121	2,111,252	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	167,910	118,373	15,120	97,721	28,736	192.00
192.01	19201	OCCUPATIONAL MEDICINE	89,639	20,738	9,460	17,120	7,070	192.01
192.02	19202	VACANT SPACE	0	4,436	2,024	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	33,131,870	1,611,830	651,839	1,326,962	2,147,058	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 12:43 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - OFFSITE	LAUNDRY & LINEN SERVICE	
			4A	5.00	7.00	7.01	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,622,369	6,622,369				5.00
7.00	00700	OPERATION OF PLANT	5,181,095	1,294,297	6,475,392			7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	14,739	3,682	0	18,421		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	182,399	45,565	168,550	0	396,514	8.00
9.00	00900	HOUSEKEEPING	473,365	118,252	100,506	0	0	9.00
10.00	01000	DIETARY	324,329	81,021	140,042	0	0	10.00
11.00	01100	CAFETERIA	540,608	135,050	295,119	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	827,888	206,816	229,675	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	960,849	240,031	217,398	0	0	14.00
15.00	01500	PHARMACY	894,304	223,407	78,345	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,896,860	723,667	1,010,260	0	396,514	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,940,243	484,694	1,273,646	0	0	50.00
53.00	05300	ANESTHESIOLOGY	70,331	17,569	24,034	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,677,262	418,998	656,773	0	0	54.00
60.00	06000	LABORATORY	1,338,751	334,435	256,779	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	631,240	157,691	15,502	0	0	65.00
66.00	06600	PHYSICAL THERAPY	898,781	224,525	86,772	8,476	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	298,449	74,556	101,130	2,615	0	67.00
69.00	06900	ELECTROCARDIOLOGY	584,754	146,078	172,452	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	292,896	73,169	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,506,110	376,243	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,706,703	426,353	0	0	0	73.00
73.01	03480	ONCOLOGY	304,462	76,058	102,899	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	198,024	49,469	121,158	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,186,712	546,265	727,054	0	0	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)	32,553,523	6,477,891	5,778,094	11,091	396,514	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	427,860	106,884	538,476	7,330	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	144,027	35,980	130,834	0	0	192.01
192.02	19202	VACANT SPACE	6,460	1,614	27,988	0	0	192.02
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	33,131,870	6,622,369	6,475,392	18,421	396,514	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 12:43 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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
7.01	00701	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	692,123					9.00
10.00	01000	DIETARY	14,625	560,017				10.00
11.00	01100	CAFETERIA	30,819	0	1,001,596			11.00
13.00	01300	NURSING ADMINISTRATION	23,985	0	47,110	1,335,474		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22,703	0	0	0	1,440,981	14.00
15.00	01500	PHARMACY	8,182	0	49,040	0	5,305	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	105,502	560,017	254,920	801,784	49,855	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	133,007	0	105,585	206,312	350,887	50.00
53.00	05300	ANESTHESIOLOGY	2,510	0	7,149	0	405	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,587	0	112,806	83	12,464	54.00
60.00	06000	LABORATORY	26,815	0	74,703	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,619	0	46,681	0	16,573	65.00
66.00	06600	PHYSICAL THERAPY	34,220	0	64,195	0	5,719	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,561	0	22,804	0	161	67.00
69.00	06900	ELECTROCARDIOLOGY	18,009	0	37,030	25,299	6,733	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	155,039	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	797,228	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	10,746	0	19,158	28,672	5,088	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	12,653	0	10,008	34,411	498	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	75,926	0	124,672	238,913	30,192	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)	600,469	560,017	975,861	1,335,474	1,436,147	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	77,991	0	18,801	0	3,557	192.00
192.01	19201	OCCUPATIONAL MEDICINE	13,663	0	6,934	0	1,277	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	692,123	560,017	1,001,596	1,335,474	1,440,981	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 12:43 pm

		Cost Center Description	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			15.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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
7.01	00701	OPERATION OF PLANT - OFFSITE						7.01
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	1,258,583					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,508	6,810,887	0	6,810,887		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,920	4,505,294	0	4,505,294		50.00
53.00	05300	ANESTHESIOLOGY	1,710	123,708	0	123,708		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,753	2,949,726	0	2,949,726		54.00
60.00	06000	LABORATORY	0	2,031,483	0	2,031,483		60.00
65.00	06500	RESPIRATORY THERAPY	128	869,434	0	869,434		65.00
66.00	06600	PHYSICAL THERAPY	168	1,322,856	0	1,322,856		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	510,276	0	510,276		67.00
69.00	06900	ELECTROCARDIOLOGY	3,412	993,767	0	993,767		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	521,104	0	521,104		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,679,581	0	2,679,581		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,206,800	3,339,856	0	3,339,856		73.00
73.01	03480	ONCOLOGY	1,527	548,610	0	548,610		73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	426,221	0	426,221		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	14,420	3,944,154	0	3,944,154		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)	1,253,346	31,576,957	0	31,576,957		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45	1,180,944	0	1,180,944		192.00
192.01	19201	OCCUPATIONAL MEDICINE	5,192	337,907	0	337,907		192.01
192.02	19202	VACANT SPACE	0	36,062	0	36,062		192.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,258,583	33,131,870	0	33,131,870		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 12:43 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,149	3,261	5,902	16,312	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	111,628	50,920	92,153	254,701	5.00
7.00	00700	OPERATION OF PLANT	0	395,480	158,582	326,485	880,547	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,716	12,187	22,055	60,958	8.00
9.00	00900	HOUSEKEEPING	0	15,930	7,267	13,151	36,348	9.00
10.00	01000	DIETARY	0	22,197	10,125	18,324	50,646	10.00
11.00	01100	CAFETERIA	0	46,777	21,338	38,616	106,731	11.00
13.00	01300	NURSING ADMINISTRATION	0	36,404	16,606	30,053	83,063	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	34,458	15,718	28,446	78,622	14.00
15.00	01500	PHARMACY	0	12,418	5,665	10,251	28,334	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	160,128	73,044	132,192	365,364	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	201,876	92,088	166,656	460,620	50.00
53.00	05300	ANESTHESIOLOGY	0	3,809	1,738	3,145	8,692	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	104,100	47,486	85,938	237,524	54.00
60.00	06000	LABORATORY	0	40,700	18,566	33,599	92,865	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,457	1,121	2,028	5,606	65.00
66.00	06600	PHYSICAL THERAPY	0	51,939	6,349	42,877	101,165	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,029	1,937	13,233	31,199	67.00
69.00	06900	ELECTROCARDIOLOGY	0	27,334	12,469	22,565	62,368	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
73.01	03480	ONCOLOGY	0	16,310	7,440	13,464	37,214	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	19,204	8,760	15,853	43,817	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	115,240	52,568	95,135	262,943	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	1,468,283	625,235	1,212,121	3,305,639	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	118,373	15,120	97,721	231,214	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	20,738	9,460	17,120	47,318	192.01
192.02	19202	VACANT SPACE	0	4,436	2,024	0	6,460	192.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,611,830	651,839	1,326,962	3,590,631	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 12:43 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - OFFSITE	LAUNDRY & LINEN SERVICE	
			4.00	5.00	7.00	7.01	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,312					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,144	255,845				5.00
7.00	00700	OPERATION OF PLANT	1,140	50,009	931,696			7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	142	0	142		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	76	1,760	24,251	0	87,045	8.00
9.00	00900	HOUSEKEEPING	495	4,568	14,461	0	0	9.00
10.00	01000	DIETARY	222	3,130	20,150	0	0	10.00
11.00	01100	CAFETERIA	468	5,217	42,462	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	867	7,990	33,046	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,273	31,280	0	0	14.00
15.00	01500	PHARMACY	884	8,631	11,272	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,908	27,958	145,359	0	87,045	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,556	18,725	183,256	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	679	3,458	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,603	16,187	94,498	0	0	54.00
60.00	06000	LABORATORY	0	12,920	36,946	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	696	6,092	2,231	0	0	65.00
66.00	06600	PHYSICAL THERAPY	905	8,674	12,485	65	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	318	2,880	14,551	20	0	67.00
69.00	06900	ELECTROCARDIOLOGY	633	5,643	24,813	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,827	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,535	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,471	0	0	0	73.00
73.01	03480	ONCOLOGY	288	2,938	14,805	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	157	1,911	17,433	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,680	21,104	104,610	0	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)	16,040	250,264	831,367	85	87,045	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	218	4,129	77,477	57	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	54	1,390	18,825	0	0	192.01
192.02	19202	VACANT SPACE	0	62	4,027	0	0	192.02
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)	16,312	255,845	931,696	142	87,045	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 12:43 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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
7.01	00701	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	55,872					9.00
10.00	01000	DIETARY	1,181	75,329				10.00
11.00	01100	CAFETERIA	2,488	0	157,366			11.00
13.00	01300	NURSING ADMINISTRATION	1,936	0	7,402	134,304		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,833	0	0	0	121,008	14.00
15.00	01500	PHARMACY	660	0	7,705	0	446	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,517	75,329	40,053	80,633	4,187	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,736	0	16,589	20,748	29,466	50.00
53.00	05300	ANESTHESIOLOGY	203	0	1,123	0	34	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,537	0	17,723	8	1,047	54.00
60.00	06000	LABORATORY	2,165	0	11,737	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	131	0	7,334	0	1,392	65.00
66.00	06600	PHYSICAL THERAPY	2,762	0	10,086	0	480	66.00
67.00	06700	OCCUPATIONAL THERAPY	853	0	3,583	0	14	67.00
69.00	06900	ELECTROCARDIOLOGY	1,454	0	5,818	2,544	565	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	13,020	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	66,947	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	867	0	3,010	2,883	427	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,021	0	1,572	3,461	42	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,129	0	19,588	24,027	2,535	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)	48,473	75,329	153,323	134,304	120,602	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,296	0	2,954	0	299	192.00
192.01	19201	OCCUPATIONAL MEDICINE	1,103	0	1,089	0	107	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	55,872	75,329	157,366	134,304	121,008	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 12:43 pm

		Cost Center Description	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			15.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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
7.01	00701	OPERATION OF PLANT - OFFSITE						7.01
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	57,932					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	530	837,883	0	837,883		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	503	742,199	0	742,199		50.00
53.00	05300	ANESTHESIOLOGY	79	14,268	0	14,268		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	127	374,254	0	374,254		54.00
60.00	06000	LABORATORY	0	156,633	0	156,633		60.00
65.00	06500	RESPIRATORY THERAPY	6	23,488	0	23,488		65.00
66.00	06600	PHYSICAL THERAPY	8	136,630	0	136,630		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	53,418	0	53,418		67.00
69.00	06900	ELECTROCARDIOLOGY	157	103,995	0	103,995		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,847	0	15,847		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	81,482	0	81,482		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,547	72,018	0	72,018		73.00
73.01	03480	ONCOLOGY	70	62,502	0	62,502		73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	69,414	0	69,414		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	664	443,280	0	443,280		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)	57,691	3,187,311	0	3,187,311		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2	322,646	0	322,646		192.00
192.01	19201	OCCUPATIONAL MEDICINE	239	70,125	0	70,125		192.01
192.02	19202	VACANT SPACE	0	10,549	0	10,549		192.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	57,932	3,590,631	0	3,590,631		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 12:43 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - INTERES (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	195,479					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	0	173,302				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			194,941			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	867	867	867	10,970,126		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,538	13,538	13,538	769,096	-6,622,369	5.00
7.00	00700	OPERATION OF PLANT	47,963	42,162	47,963	766,614	0	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	3,240	3,240	3,240	51,210	0	8.00
9.00	00900	HOUSEKEEPING	1,932	1,932	1,932	332,863	0	9.00
10.00	01000	DIETARY	2,692	2,692	2,692	149,290	0	10.00
11.00	01100	CAFETERIA	5,673	5,673	5,673	314,637	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,415	4,415	4,415	583,003	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,179	4,179	4,179	0	0	14.00
15.00	01500	PHARMACY	1,506	1,506	1,506	594,628	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,420	19,420	19,420	1,955,998	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,483	24,483	24,483	1,046,730	0	50.00
53.00	05300	ANESTHESIOLOGY	462	462	462	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,625	12,625	12,625	1,078,157	0	54.00
60.00	06000	LABORATORY	4,936	4,936	4,936	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	298	298	298	467,758	0	65.00
66.00	06600	PHYSICAL THERAPY	6,299	1,688	6,299	608,453	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,944	515	1,944	213,964	0	67.00
69.00	06900	ELECTROCARDIOLOGY	3,315	3,315	3,315	425,354	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
73.01	03480	ONCOLOGY	1,978	1,978	1,978	193,937	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,329	2,329	2,329	105,367	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,976	13,976	13,976	1,130,125	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)	178,070	166,229	178,070	10,787,184	-6,622,369	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,356	4,020	14,356	146,821	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	2,515	2,515	2,515	36,121	0	192.01
192.02	19202	VACANT SPACE	538	538	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,611,830	651,839	1,326,962	2,147,058		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.245540	3.761290	6.806993	0.195719		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				16,312		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.001487		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: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 12:43 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - OFFSITE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,509,501					5.00
7.00	00700	OPERATION OF PLANT	5,181,095	124,475				7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	14,739	0	10,065			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	182,399	3,240	0	2,444		8.00
9.00	00900	HOUSEKEEPING	473,365	1,932	0	0	127,401	9.00
10.00	01000	DIETARY	324,329	2,692	0	0	2,692	10.00
11.00	01100	CAFETERIA	540,608	5,673	0	0	5,673	11.00
13.00	01300	NURSING ADMINISTRATION	827,888	4,415	0	0	4,415	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	960,849	4,179	0	0	4,179	14.00
15.00	01500	PHARMACY	894,304	1,506	0	0	1,506	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,896,860	19,420	0	2,444	19,420	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,940,243	24,483	0	0	24,483	50.00
53.00	05300	ANESTHESIOLOGY	70,331	462	0	0	462	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,677,262	12,625	0	0	12,625	54.00
60.00	06000	LABORATORY	1,338,751	4,936	0	0	4,936	60.00
65.00	06500	RESPIRATORY THERAPY	631,240	298	0	0	298	65.00
66.00	06600	PHYSICAL THERAPY	898,781	1,668	4,631	0	6,299	66.00
67.00	06700	OCCUPATIONAL THERAPY	298,449	1,944	1,429	0	1,944	67.00
69.00	06900	ELECTROCARDIOLOGY	584,754	3,315	0	0	3,315	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	292,896	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,506,110	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,706,703	0	0	0	0	73.00
73.01	03480	ONCOLOGY	304,462	1,978	0	0	1,978	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	198,024	2,329	0	0	2,329	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,186,712	13,976	0	0	13,976	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)	25,931,154	111,071	6,060	2,444	110,530	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	427,860	10,351	4,005	0	14,356	192.00
192.01	19201	OCCUPATIONAL MEDICINE	144,027	2,515	0	0	2,515	192.01
192.02	19202	VACANT SPACE	6,460	538	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,622,369	6,475,392	18,421	396,514	692,123	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.249811	52.021627	1.830204	162.239771	5.432634	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	255,845	931,696	142	87,045	55,872	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009651	7.485005	0.014108	35.615794	0.438552	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: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 12:43 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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
7.01	00701	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	8,586					10.00
11.00	01100	CAFETERIA	0	14,011				11.00
13.00	01300	NURSING ADMINISTRATION	0	659	112,858			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,722,273		14.00
15.00	01500	PHARMACY	0	686	0	10,023	1,779,936	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,586	3,566	67,757	94,185	16,275	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,477	17,435	662,888	15,443	50.00
53.00	05300	ANESTHESIOLOGY	0	100	0	765	2,418	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,578	7	23,546	3,893	54.00
60.00	06000	LABORATORY	0	1,045	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	653	0	31,309	181	65.00
66.00	06600	PHYSICAL THERAPY	0	898	0	10,804	237	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	319	0	304	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	518	2,138	12,720	4,825	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	292,896	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,506,110	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,706,703	73.00
73.01	03480	ONCOLOGY	0	268	2,423	9,613	2,160	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	140	2,908	941	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	1,744	20,190	57,038	20,394	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)	8,586	13,651	112,858	2,713,142	1,772,529	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	263	0	6,719	64	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	97	0	2,412	7,343	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	560,017	1,001,596	1,335,474	1,440,981	1,258,583	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	65.224435	71.486404	11.833224	0.529330	0.707095	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	75,329	157,366	134,304	121,008	57,932	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.773468	11.231604	1.190026	0.044451	0.032547	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: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 12:43 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	6,810,887		6,810,887	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,505,294		4,505,294	0	0	50.00
53.00	05300	ANESTHESIOLOGY	123,708		123,708	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,949,726		2,949,726	0	0	54.00
60.00	06000	LABORATORY	2,031,483		2,031,483	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	869,434	0	869,434	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,322,856	0	1,322,856	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	510,276	0	510,276	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	993,767		993,767	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	521,104		521,104	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,679,581		2,679,581	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,339,856		3,339,856	0	0	73.00
73.01	03480	ONCOLOGY	548,610		548,610	0	0	73.01
76.00	03160	CARDIOPULMONARY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	426,221		426,221	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,944,154		3,944,154	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,225,273		1,225,273		0	92.00
200.00		Subtotal (see instructions)	32,802,230	0	32,802,230	0	0	200.00
201.00		Less Observation Beds	1,225,273		1,225,273		0	201.00
202.00		Total (see instructions)	31,576,957	0	31,576,957	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 12:43 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	5,094,591		5,094,591			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,924,389	16,824,256	25,748,645	0.174972	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	408,146	622,052	1,030,198	0.120082	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	379,320	8,465,799	8,845,119	0.333486	0.000000	54.00
60.00	06000	LABORATORY	768,987	4,462,935	5,231,922	0.388286	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	476,023	528,880	1,004,903	0.865192	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	844,966	1,654,123	2,499,089	0.529335	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	397,983	477,473	875,456	0.582869	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	219,494	4,116,069	4,335,563	0.229213	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,559,341	2,000,504	3,559,845	0.146384	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,941,173	4,163,462	15,104,635	0.177401	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,343,412	7,964,299	10,307,711	0.324015	0.000000	73.00
73.01	03480	ONCOLOGY	0	1,110,522	1,110,522	0.494011	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	667,147	667,147	0.638871	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	374,102	11,102,426	11,476,528	0.343671	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,256	3,095,805	3,107,061	0.394351	0.000000	92.00
200.00		Subtotal (see instructions)	32,743,183	67,255,752	99,998,935			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	32,743,183	67,255,752	99,998,935			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 12:43 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
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
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
73.01	03480	ONCOLOGY	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 12:43 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,810,887		6,810,887	0	6,810,887	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,505,294		4,505,294	0	4,505,294	50.00
53.00	05300	ANESTHESIOLOGY	123,708		123,708	0	123,708	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,949,726		2,949,726	0	2,949,726	54.00
60.00	06000	LABORATORY	2,031,483		2,031,483	0	2,031,483	60.00
65.00	06500	RESPIRATORY THERAPY	869,434	0	869,434	0	869,434	65.00
66.00	06600	PHYSICAL THERAPY	1,322,856	0	1,322,856	0	1,322,856	66.00
67.00	06700	OCCUPATIONAL THERAPY	510,276	0	510,276	0	510,276	67.00
69.00	06900	ELECTROCARDIOLOGY	993,767		993,767	0	993,767	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	521,104		521,104	0	521,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,679,581		2,679,581	0	2,679,581	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,339,856		3,339,856	0	3,339,856	73.00
73.01	03480	ONCOLOGY	548,610		548,610	0	548,610	73.01
76.00	03160	CARDIOPULMONARY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	426,221		426,221	0	426,221	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,944,154		3,944,154	0	3,944,154	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,225,273		1,225,273		1,225,273	92.00
200.00		Subtotal (see instructions)	32,802,230	0	32,802,230	0	32,802,230	200.00
201.00		Less Observation Beds	1,225,273		1,225,273		1,225,273	201.00
202.00		Total (see instructions)	31,576,957	0	31,576,957	0	31,576,957	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 12:43 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,094,591		5,094,591			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,924,389	16,824,256	25,748,645	0.174972	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	408,146	622,052	1,030,198	0.120082	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	379,320	8,465,799	8,845,119	0.333486	0.000000	54.00
60.00	06000	LABORATORY	768,987	4,462,935	5,231,922	0.388286	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	476,023	528,880	1,004,903	0.865192	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	844,966	1,654,123	2,499,089	0.529335	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	397,983	477,473	875,456	0.582869	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	219,494	4,116,069	4,335,563	0.229213	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,559,341	2,000,504	3,559,845	0.146384	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,941,173	4,163,462	15,104,635	0.177401	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,343,412	7,964,299	10,307,711	0.324015	0.000000	73.00
73.01	03480	ONCOLOGY	0	1,110,522	1,110,522	0.494011	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	667,147	667,147	0.638871	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	374,102	11,102,426	11,476,528	0.343671	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,256	3,095,805	3,107,061	0.394351	0.000000	92.00
200.00		Subtotal (see instructions)	32,743,183	67,255,752	99,998,935			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	32,743,183	67,255,752	99,998,935			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 12:43 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
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
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
73.01	03480	ONCOLOGY	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 12:43 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	742,199	25,748,645	0.028825	3,743,326	107,901	50.00
53.00	05300	ANESTHESIOLOGY	14,268	1,030,198	0.013850	169,716	2,351	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	374,254	8,845,119	0.042312	156,093	6,605	54.00
60.00	06000	LABORATORY	156,633	5,231,922	0.029938	389,757	11,669	60.00
65.00	06500	RESPIRATORY THERAPY	23,488	1,004,903	0.023373	279,316	6,528	65.00
66.00	06600	PHYSICAL THERAPY	136,630	2,499,089	0.054672	368,003	20,119	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,418	875,456	0.061017	196,799	12,008	67.00
69.00	06900	ELECTROCARDIOLOGY	103,995	4,335,563	0.023987	120,540	2,891	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,847	3,559,845	0.004452	603,330	2,686	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81,482	15,104,635	0.005395	4,807,947	25,939	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,018	10,307,711	0.006987	1,075,106	7,512	73.00
73.01	03480	ONCOLOGY	62,502	1,110,522	0.056282	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	69,414	667,147	0.104046	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	443,280	11,476,528	0.038625	15,252	589	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	150,734	3,107,061	0.048513	0	0	92.00
200.00		Total (lines 50 through 199)	2,500,162	94,904,344		11,925,185	206,798	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 12:43 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 12:43 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	25,748,645	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,030,198	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,845,119	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	5,231,922	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,004,903	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,499,089	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	875,456	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,335,563	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,559,845	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,104,635	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,307,711	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	1,110,522	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	667,147	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	11,476,528	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,107,061	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	94,904,344		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 12:43 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	3,743,326	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	169,716	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	156,093	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	389,757	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	279,316	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	368,003	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	196,799	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	120,540	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	603,330	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,807,947	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,075,106	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	15,252	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		11,925,185	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 12:43 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	0.174972	0	3,894,125	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.120082	0	113,442	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.333486	0	2,767,978	0	0	54.00
60.00	06000	LABORATORY	0.388286	0	1,436,218	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.865192	0	199,063	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.529335	0	699,239	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.582869	0	187,309	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.229213	0	1,509,394	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.146384	0	342,198	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.177401	0	762,030	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.324015	0	3,693,397	9,221	0	73.00
73.01	03480	ONCOLOGY	0.494011	0	605,573	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.638871	0	277,080	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.343671	0	3,261,200	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.394351	0	1,254,158	0	0	92.00
200.00		Subtotal (see instructions)		0	21,002,404	9,221	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	21,002,404	9,221	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 12:43 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	681,363	0		50.00
53.00	05300	ANESTHESIOLOGY	13,622	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	923,082	0		54.00
60.00	06000	LABORATORY	557,663	0		60.00
65.00	06500	RESPIRATORY THERAPY	172,228	0		65.00
66.00	06600	PHYSICAL THERAPY	370,132	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	109,177	0		67.00
69.00	06900	ELECTROCARDIOLOGY	345,973	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,092	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	135,185	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,196,716	2,988		73.00
73.01	03480	ONCOLOGY	299,160	0		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	177,018	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,120,780	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	494,578	0		92.00
200.00		Subtotal (see instructions)	6,646,769	2,988		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,646,769	2,988		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 12:43 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	0.174972	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.120082	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.333486	0	0	0	0	54.00
60.00	06000	LABORATORY	0.388286	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.865192	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.529335	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.582869	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.229213	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.146384	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.177401	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.324015	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0.494011	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.638871	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.343671	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.394351	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: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 12:43 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
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
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
73.01	03480	ONCOLOGY	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	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: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 12:43 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.174972	0	153,315	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.120082	0	11,808	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.333486	0	54,243	0	0	54.00
60.00	06000	LABORATORY	0.388286	0	42,202	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.865192	0	2,095	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.529335	0	1,448	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.582869	0	2,279	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.229213	0	39,609	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.146384	0	11,699	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.177401	0	18,176	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.324015	0	21,650	0	0	73.00
73.01	03480	ONCOLOGY	0.494011	0	461	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.638871	0	5,868	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.343671	0	241,014	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.394351	0	4,316	0	0	92.00
200.00		Subtotal (see instructions)		0	610,183	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	610,183	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 12:43 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	26,826	0		50.00
53.00	05300	ANESTHESIOLOGY	1,418	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,089	0		54.00
60.00	06000	LABORATORY	16,386	0		60.00
65.00	06500	RESPIRATORY THERAPY	1,813	0		65.00
66.00	06600	PHYSICAL THERAPY	766	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,328	0		67.00
69.00	06900	ELECTROCARDIOLOGY	9,079	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,713	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,224	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,015	0		73.00
73.01	03480	ONCOLOGY	228	0		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	3,749	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	82,830	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,702	0		92.00
200.00		Subtotal (see instructions)	176,166	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	176,166	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 12:43 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)	3,481	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,063	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)	2,444	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	375	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	43	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)	1,441	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)	375	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	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,810,887	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)	5,553	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)	747,847	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,063,040	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)	6,063,040	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)	1,979.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,852,387	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)	2,852,387	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 12:43 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						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)	2,752,390	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,604,777	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)	742,294	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)	742,294	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)	619	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,979.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,225,273	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 12:43 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	837,883	6,810,887	0.123021	1,225,273	150,734	90.00
91.00	Nursing School cost	0	6,810,887	0.000000	1,225,273	0	91.00
92.00	Allied health cost	0	6,810,887	0.000000	1,225,273	0	92.00
93.00	All other Medical Education	0	6,810,887	0.000000	1,225,273	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1311	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 12:43 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)	3,481	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,063	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)	2,444	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	375	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	43	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)	0	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)	375	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,810,887	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	742,898	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,067,989	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)	6,067,989	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)	1,981.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 12:43 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	0	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)	742,898	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)	742,898	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)	619	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,981.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,226,276	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 12:43 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	837,883	6,810,887	0.123021	1,226,276	150,858	90.00
91.00	Nursing School cost	0	6,810,887	0.000000	1,226,276	0	91.00
92.00	Allied health cost	0	6,810,887	0.000000	1,226,276	0	92.00
93.00	All other Medical Education	0	6,810,887	0.000000	1,226,276	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 12:43 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		2,812,204		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.174972	3,743,326	654,977	50.00
53.00	05300	ANESTHESIOLOGY	0.120082	169,716	20,380	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.333486	156,093	52,055	54.00
60.00	06000	LABORATORY	0.388286	389,757	151,337	60.00
65.00	06500	RESPIRATORY THERAPY	0.865192	279,316	241,662	65.00
66.00	06600	PHYSICAL THERAPY	0.529335	368,003	194,797	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.582869	196,799	114,708	67.00
69.00	06900	ELECTROCARDIOLOGY	0.229213	120,540	27,629	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.146384	603,330	88,318	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.177401	4,807,947	852,935	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.324015	1,075,106	348,350	73.00
73.01	03480	ONCOLOGY	0.494011	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.638871	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.343671	15,252	5,242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.394351	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,925,185	2,752,390	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)		11,925,185		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 12:43 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.174972	4,702	823	50.00
53.00	05300	ANESTHESIOLOGY	0.120082	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.333486	15,015	5,007	54.00
60.00	06000	LABORATORY	0.388286	56,778	22,046	60.00
65.00	06500	RESPIRATORY THERAPY	0.865192	51,672	44,706	65.00
66.00	06600	PHYSICAL THERAPY	0.529335	135,330	71,635	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.582869	65,670	38,277	67.00
69.00	06900	ELECTROCARDIOLOGY	0.229213	4,196	962	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.146384	1,848	271	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.177401	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.324015	158,753	51,438	73.00
73.01	03480	ONCOLOGY	0.494011	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.638871	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.343671	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.394351	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		493,964	235,165	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)		493,964		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 12:43 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		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.174972	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.120082	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.333486	0	0	54.00
60.00	06000	LABORATORY	0.388286	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.865192	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.529335	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.582869	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.229213	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.146384	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.177401	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.324015	0	0	73.00
73.01	03480	ONCOLOGY	0.494011	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.638871	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.343671	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.394351	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: 15-1311	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 12:43 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,649,757	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)	6,649,757	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)	6,716,255	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)	29,776	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,873,411	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)	2,813,068	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)	2,813,068	30.00
31.00	Primary payer payments	318	31.00
32.00	Subtotal (line 30 minus line 31)	2,812,750	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)	515,188	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	334,872	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	343,021	36.00
37.00	Subtotal (see instructions)	3,147,622	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)	3,147,622	40.00
40.01	Sequestration adjustment (see instructions)	62,952	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,135,301	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	949,369	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	207,328	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: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2019 12:43 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		4,865,136		2,010,601	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	05/16/2018	94,900	08/22/2018	124,700	3.01
3.02		08/22/2018	62,100		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)		157,000		124,700	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)		5,022,136		2,135,301	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		139,710		949,369	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		5,161,846		3,084,670	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: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 12:43 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		761,862		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	08/22/2018	198,700		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		198,700		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		960,562		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		7,493		0	6.02
7.00	Total Medicare program liability (see instructions)		953,069		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: 15-1311	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/29/2019 12:43 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: 15-1311 Component CCN: 15-Z311	Period: From 01/01/2018 To 12/31/2018	Worksheet E-2 Date/Time Prepared: 5/29/2019 12:43 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)	749,717	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)	237,517	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	375	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)	987,234	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	987,234	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)	987,234	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	16,888	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)	970,346	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)	3,343	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	2,173	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	972,519	0	19.00
19.01	Sequestration adjustment (see instructions)	19,450	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	960,562	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)	-7,493	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	30,488	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: 15-1311	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/29/2019 12:43 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,604,777	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)	5,604,777	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,660,825	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)	5,660,825	19.00
20.00	Deductibles (exclude professional component)	419,348	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,241,477	22.00
23.00	Coinsurance	2,345	23.00
24.00	Subtotal (line 22 minus line 23)	5,239,132	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	43,166	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	28,058	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,165	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,267,190	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)	5,267,190	30.00
30.01	Sequestration adjustment (see instructions)	105,344	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	5,022,136	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)	139,710	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	174,798	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/29/2019 12:43 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	25,396,638	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	5,370,243	0	0	0	4.00
5.00	Other receivable	-1,430,890	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	617,266	0	0	0	7.00
8.00	Prepaid expenses	178,412	0	0	0	8.00
9.00	Other current assets	0	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)	30,131,669	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	9,019,573	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	2,872,457	0	0	0	17.00
18.00	Accumulated depreciation	-1,115,535	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	12,518,097	0	0	0	23.00
24.00	Accumulated depreciation	-9,333,892	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,960,700	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	424,983	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	14,177,673	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,602,656	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	58,695,025	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,451,261	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,093,366	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,149,467	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,694,094	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	14,775,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	377,222	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,152,222	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	21,846,316	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	36,848,709				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)	36,848,709	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	58,695,025	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/29/2019 12:43 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		32,770,675		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,390,801				2.00
3.00	Total (sum of line 1 and line 2)		36,161,476		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	TEMP RESTRICTED	686,818		0		0	5.00
6.00	PERM RESTRICTED	13,927		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)		700,745		0		10.00
11.00	Subtotal (line 3 plus line 10)		36,862,221		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	UNRESTRICTED FUND BALANCE	13,506		0		0	13.00
14.00	ROUNDING	6		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)		13,512		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		36,848,709		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	TEMP RESTRICTED		0			5.00
6.00	PERM RESTRICTED		0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	UNRESTRICTED FUND BALANCE		0			13.00
14.00	ROUNDING		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: 15-1311 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2019 12:43 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,768,737		4,768,737	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	325,854		325,854	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)	5,094,591		5,094,591	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,094,591		5,094,591	17.00
18.00	Ancillary services	27,263,233	53,057,441	80,320,674	18.00
19.00	Outpatient services	385,358	14,198,311	14,583,669	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	NON-ALLOWABLE REVENUE	0	2,611,629	2,611,629	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	32,743,182	69,867,381	102,610,563	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,108,926		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)		36,108,926		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1311	Period: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 5/29/2019 12:43 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	102,610,563	1.00
2.00	Less contractual allowances and discounts on patients' accounts	64,466,512	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,144,051	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,108,926	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,035,125	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	1,355,676	24.00
25.00	Total other income (sum of lines 6-24)	1,355,676	25.00
26.00	Total (line 5 plus line 25)	3,390,801	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)	3,390,801	29.00