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: 15-1312	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/28/2019 6:19 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/28/2019 Time: 6:19 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 WHITE HOSPITAL (15-1312) 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) TODD WILLIAMS
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	165,330	134,865	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	97,325	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	262,655	134,865	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 6:19 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 720 SOUTH SIXTH STREET	PO Box:			1.00
2.00	City: MONTICELLO	State: IN	Zip Code: 47960	County: WHITE	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 WHITE HOSPITAL	151312	99915	1	07/01/1966	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 WHITE HOSPITAL	15Z312	99915		02/16/1990	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	HOME CARE OF WHITE COUNTY	157514	99915		03/01/1997	N	N	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2019 6:19 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	
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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 6:19 pm

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 6:19 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1312	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 6:19 pm

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

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

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

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

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		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:	39,167	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: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2019 6:19 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	51	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/28/2019 6:19 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/03/2019	Y	04/03/2019	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 6:19 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.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA		UTTER		41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.962.1093		RUTTER@IUHEALTH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1312	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 6:19 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.	GOVERNMENT PROGRAMS DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/28/2019 6:19 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	41,568.00	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	41,568.00	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	41,568.00	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	101.00				0	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: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2019 6:19 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)	1,147	7	1,732			1.00
2.00	HMO and other (see instructions)	198	113				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	319	0	319			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	213			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,466	7	2,264			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)	1,466	7	2,264	0.00	138.89	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	0	0	0	0.00	0.00	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	138.89	27.00
28.00	Observation Bed Days		3	446			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: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2019 6:19 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	346	2	550	1.00
2.00	HMO and other (see instructions)			61	41		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	346	2	550	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	0.00					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: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/28/2019 6:19 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)	0.323295	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,472,043	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	12,564,281	6.00
7.00	Medicaid cost (line 1 times line 6)	4,061,969	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)	1,589,926	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)	1,589,926	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,415,394	75,435	2,490,829	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	780,885	75,435	856,320	21.00
22.00	Payments received from patients for amounts previously written off as charity care	8,495	1,980	10,475	22.00
23.00	Cost of charity care (line 21 minus line 22)	772,390	73,455	845,845	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)	2,947,746	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	460,886	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	709,054	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,238,692	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	971,926	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,817,771	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,407,697	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/28/2019 6:19 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,902,203	1,902,203	-1,890,627	11,576	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL		0	0	2,717,096	2,717,096	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB		0	0	281,117	281,117	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	46,160	46,160	1,460,743	1,506,903	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	480,760	6,356,621	6,837,381	-103,522	6,733,859	5.00
7.00	00700	OPERATION OF PLANT	215,017	1,833,539	2,048,556	-1,817,561	230,995	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	0	0	1,728,594	1,728,594	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	0	0	294,897	294,897	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	68,966	68,966	8.00
9.00	00900	HOUSEKEEPING	324,941	260,368	585,309	-197,568	387,741	9.00
10.00	01000	DIETARY	523,795	402,903	926,698	-310,179	616,519	10.00
11.00	01100	CAFETERIA	0	0	0	112,365	112,365	11.00
13.00	01300	NURSING ADMINISTRATION	721,311	234,458	955,769	-116,883	838,886	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	116,970	116,970	544,935	661,905	14.00
15.00	01500	PHARMACY	404,373	2,330,280	2,734,653	-2,033,251	701,402	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,224,924	929,343	2,154,267	-411,130	1,743,137	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	463,082	728,926	1,192,008	-275,785	916,223	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	310,688	404,081	714,769	-261,800	452,969	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	79,747	81,485	161,232	-53,525	107,707	55.00
56.00	03630	ULTRA SOUND	138,387	101,352	239,739	-83,832	155,907	56.00
57.00	05700	CT SCAN	384,538	247,326	631,864	-217,445	414,419	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	114,396	172,727	287,123	-165,396	121,727	58.00
60.00	06000	LABORATORY	0	1,372,231	1,372,231	0	1,372,231	60.00
66.00	06600	PHYSICAL THERAPY	289,577	88,539	378,116	-64,880	313,236	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,246	25,217	138,463	-16,725	121,738	67.00
68.00	06800	SPEECH PATHOLOGY	69,067	19,776	88,843	-14,551	74,292	68.00
69.00	06900	ELECTROCARDIOLOGY	95,070	38,578	133,648	-25,893	107,755	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	20,626	20,626	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,676	6,676	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	324,414	324,414	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	1,668,014	1,668,014	73.01
76.00	03160	CARDIOPULMONARY	421,375	198,650	620,025	-116,311	503,714	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	115,366	63,901	179,267	-36,381	142,886	90.00
91.00	09100	EMERGENCY	1,180,933	1,801,709	2,982,642	-420,978	2,561,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,670,593	19,757,343	27,427,936	594,220	28,022,156	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	87,427	23,550	110,977	-18,206	92,771	192.00
192.02	19202	MOB	0	576,014	576,014	-576,014	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	7,758,020	20,356,907	28,114,927	0	28,114,927	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/28/2019 6:19 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	44,008	55,584		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	-259,165	2,457,931		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	338,217	619,334		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-20,792	1,486,111		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-459,832	6,274,027		5.00
7.00	00700	OPERATION OF PLANT	0	230,995		7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	-8,380	1,720,214		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	294,897		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,966		8.00
9.00	00900	HOUSEKEEPING	0	387,741		9.00
10.00	01000	DIETARY	-139,847	476,672		10.00
11.00	01100	CAFETERIA	-111,273	1,092		11.00
13.00	01300	NURSING ADMINISTRATION	-12,703	826,183		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-12,411	649,494		14.00
15.00	01500	PHARMACY	295,144	996,546		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-245,262	1,497,875		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-125,349	790,874		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,762	451,207		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	107,707		55.00
56.00	03630	ULTRA SOUND	0	155,907		56.00
57.00	05700	CT SCAN	0	414,419		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	121,727		58.00
60.00	06000	LABORATORY	0	1,372,231		60.00
66.00	06600	PHYSICAL THERAPY	0	313,236		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	121,738		67.00
68.00	06800	SPEECH PATHOLOGY	0	74,292		68.00
69.00	06900	ELECTROCARDIOLOGY	0	107,755		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,626		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,676		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	324,414		73.00
73.01	07301	ONCOLOGY DRUGS	0	1,668,014		73.01
76.00	03160	CARDIOPULMONARY	-24,306	479,408		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-1,511	141,375		90.00
91.00	09100	EMERGENCY	58,502	2,620,166		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-686,722	27,335,434		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	92,771		192.00
192.02	19202	MOB	0	0		192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0		192.04
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-686,722	27,428,205		200.00

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 6:19 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	78,446	33,919	1.00
	0		78,446	33,919	
	B - DRUGS EXPENSE				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	324,414	1.00
2.00	ONCOLOGY DRUGS	73.01	0	1,668,014	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
	0		0	1,992,428	
	C - MEDICAL SUPPLIES AND REBATES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	550,916	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	20,626	2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,676	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	0		0	578,218	
	D - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	68,966	1.00
2.00		0.00	0	0	2.00
	0		0	68,966	
	E - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	1,631,497	1.00
2.00	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	250,741	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 6:19 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	0		0	1,882,238	
	F - OTHER CAPITAL EXPENSES				
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	1,060,020	1.00
2.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	25,579	2.00
3.00	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	30,376	3.00
	TOTALS		0	1,115,975	
	G - OPERATION OF PLANT				
1.00	OPERATION OF PLANT - HOSPITAL	7.01	0	1,728,594	1.00
2.00	OPERATION OF PLANT - TLMOB	7.02	0	294,897	2.00
	0		0	2,023,491	
	H - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,463,150	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	0		0	1,463,150	
	I - HOUSEKEEPING SUPPLIES				
1.00	HOUSEKEEPING	9.00	0	7,186	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
	0		0	7,186	
	J - NON-CAPITAL EXPENSES				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	236	1.00
	TOTALS		0	236	
500.00	Grand Total: Increases		78,446	9,165,807	500.00

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 6:19 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	78,446	33,919	0		1.00
	0		78,446	33,919			
	B - DRUGS EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	534	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	2	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	636	0		3.00
4.00	PHARMACY	15.00	0	1,932,308	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	5,626	0		5.00
6.00	OPERATING ROOM	50.00	0	5,145	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	436	0		7.00
8.00	RADIOLOGY-THERAPEUTIC	55.00	0	23,168	0		8.00
9.00	CT SCAN	57.00	0	7,403	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	7	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	43	0		11.00
12.00	CARDIOPULMONARY	76.00	0	3,980	0		12.00
13.00	CLINIC	90.00	0	2,247	0		13.00
14.00	EMERGENCY	91.00	0	10,884	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9	0		15.00
	0		0	1,992,428			
	C - MEDICAL SUPPLIES AND REBATES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	459	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	757	0		2.00
3.00	OPERATION OF PLANT	7.00	0	23,379	0		3.00
4.00	HOUSEKEEPING	9.00	0	24,943	0		4.00
5.00	DIETARY	10.00	0	3,014	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	200	0		6.00
7.00	PHARMACY	15.00	0	17,538	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	82,283	0		8.00
9.00	OPERATING ROOM	50.00	0	134,717	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,587	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	533	0		11.00
12.00	ULTRA SOUND	56.00	0	4,549	0		12.00
13.00	CT SCAN	57.00	0	48,595	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	14,287	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	3,706	0		15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	181	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	6,343	0		17.00
18.00	CARDIOPULMONARY	76.00	0	20,978	0		18.00
19.00	CLINIC	90.00	0	5,938	0		19.00
20.00	EMERGENCY	91.00	0	180,038	0		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,193	0		21.00
	0		0	578,218			
	D - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	63,682	0		1.00
2.00	DIETARY	10.00	0	5,284	0		2.00
	0		0	68,966			
	E - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	830,371	9		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,414	9		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	16,762	0		3.00
4.00	OPERATION OF PLANT	7.00	0	10,396	0		4.00
5.00	DIETARY	10.00	0	50,324	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,345	0		6.00
7.00	PHARMACY	15.00	0	44,633	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	70,915	0		8.00
9.00	OPERATING ROOM	50.00	0	60,159	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	187,154	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	14,803	0		11.00
12.00	ULTRA SOUND	56.00	0	62,261	0		12.00
13.00	CT SCAN	57.00	0	87,717	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	125,915	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	524	0		15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	120	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	3,890	0		17.00
18.00	CARDIOPULMONARY	76.00	0	3,098	0		18.00
19.00	CLINIC	90.00	0	29	0		19.00
20.00	EMERGENCY	91.00	0	53,227	0		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,440	0		21.00
22.00	MOB	192.02	0	250,741	0		22.00
	0		0	1,882,238			

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 6:19 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	F - OTHER CAPITAL EXPENSES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,060,020	11		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	25,579	12		2.00
3.00	MOB	192.02	0	30,376	13		3.00
	TOTALS		0	1,115,975			
	G - OPERATION OF PLANT						
1.00	OPERATION OF PLANT	7.00	0	1,728,594	0		1.00
2.00	MOB	192.02	0	294,897	0		2.00
	0		0	2,023,491			
	H - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	60,659	0		1.00
2.00	OPERATION OF PLANT	7.00	0	55,192	0		2.00
3.00	HOUSEKEEPING	9.00	0	116,129	0		3.00
4.00	DIETARY	10.00	0	133,651	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	116,461	0		5.00
6.00	PHARMACY	15.00	0	38,123	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	252,137	0		7.00
8.00	OPERATING ROOM	50.00	0	75,748	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	70,543	0		9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	15,021	0		10.00
11.00	ULTRA SOUND	56.00	0	16,804	0		11.00
12.00	CT SCAN	57.00	0	73,730	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	25,194	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	60,643	0		14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	16,424	0		15.00
16.00	SPEECH PATHOLOGY	68.00	0	14,549	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	15,551	0		17.00
18.00	CARDIOPULMONARY	76.00	0	88,220	0		18.00
19.00	CLINIC	90.00	0	28,145	0		19.00
20.00	EMERGENCY	91.00	0	176,662	0		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	13,564	0		21.00
	0		0	1,463,150			
	I - HOUSEKEEPING SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1	0		1.00
2.00	DIETARY	10.00	0	5,541	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	220	0		3.00
4.00	PHARMACY	15.00	0	649	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	169	0		5.00
6.00	OPERATING ROOM	50.00	0	16	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	80	0		7.00
8.00	ULTRA SOUND	56.00	0	218	0		8.00
9.00	SPEECH PATHOLOGY	68.00	0	2	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	66	0		10.00
11.00	CARDIOPULMONARY	76.00	0	35	0		11.00
12.00	CLINIC	90.00	0	22	0		12.00
13.00	EMERGENCY	91.00	0	167	0		13.00
	0		0	7,186			
	J - NON-CAPITAL EXPENSES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	236	12		1.00
	TOTALS		0	236			
500.00	Grand Total: Decreases		78,446	9,165,807			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I Date/Time Prepared: 5/28/2019 6:19 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	954,570	0	0	0	0	1.00
2.00	Land Improvements	1,046,080	0	0	0	154,793	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	40,396,582	0	0	0	1,800,079	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	5,069,275	1,350,788	0	1,350,788	230,036	6.00
7.00	HIT designated Assets	15,000	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	47,481,507	1,350,788	0	1,350,788	2,184,908	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	47,481,507	1,350,788	0	1,350,788	2,184,908	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	954,570	0	1.00
2.00	Land Improvements	891,287	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	38,596,503	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	6,190,027	1,501,937	6.00
7.00	HIT designated Assets	15,000	15,000	7.00
8.00	Subtotal (sum of lines 1-7)	46,647,387	1,516,937	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	46,647,387	1,516,937	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/28/2019 6:19 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	841,947	0	1,060,020	71	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	841,947	0	1,060,020	71	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	165	1,902,203	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	1.02
3.00	Total (sum of lines 1-2)	165	1,902,203	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III | Date/Time Prepared: 5/28/2019 6:19 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,845,857	0	1,845,857	0.039570	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	29,866,326	0	29,866,326	0.640258	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	14,935,204	0	14,935,204	0.320172	0	1.02
3.00	Total (sum of lines 1-2)	46,647,387	0	46,647,387	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	55,584	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	1,782,533	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	588,958	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	2,427,075	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	-165	0	165	55,584	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	649,819	25,579	0	0	2,457,931	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	30,376	0	619,334	1.02
3.00	Total (sum of lines 1-2)	649,819	25,414	30,376	165	3,132,849	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/28/2019 6:19 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 - HOSPITAL (chapter 2)	B	-444,638	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	11	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT - TLMOB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	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	-370,923			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	2,607,776			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-53,576	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	44,008	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - HOSPITAL	A	87,945	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT - TLMOB	A	338,217	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	9	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/28/2019 6:19 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-34,437	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	32.00
33.00	CRNA COSTS	A	-47,625	OPERATING ROOM	50.00	0	33.00
33.01	EMPLOYEE BENEFITS	A	-1,463,150	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	LOSS ON ABANDONMENT	A	97,528	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	33.02
33.03	MARKETING	A	-1,511	CLINIC	90.00	0	33.03
33.04	MEDICAID HAF FEES	A	-1,121,062	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-4,379	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-57,697	CAFETERIA	11.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-4,849	NURSING ADMINISTRATION	13.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-12,411	CENTRAL SERVICES & SUPPLY	14.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-4,035	PHARMACY	15.00	0	33.09
33.10	MISCELLANEOUS INCOME	B	-1,316	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11	WIC PROGRAM COSTS	A	-217,929	DIETARY	10.00	0	33.11
33.12	WIC PROGRAM BENEFIT COSTS	A	-27,277	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	ACCRUED PTO - GENERAL	A	20,065	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	CONTRIBUTION EXPENSE	A	-15,000	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	TELEPHONE EXPENSE	A	-446	RADIOLOGY-DIAGNOSTIC	54.00	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-686,722				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: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/28/2019 6:19 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	1.01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOCATION	1,094,457	1,060,020	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1,469,635	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4,157,591	4,111,036	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	POOLED CAPITAL - H.O.	561,797	0	3.01
3.02	13.00	NURSING ADMINISTRATION	HOME OFFICE ALLOCATION	0	30,029	3.02
4.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	825,490	773,298	4.00
4.01	7.01	OPERATION OF PLANT - HOSPITA	RELATED PARTY	44,612	52,992	4.01
4.02	10.00	DIETARY	RELATED PARTY	78,082	0	4.02
4.03	13.00	NURSING ADMINISTRATION	RELATED PARTY	22,175	0	4.03
4.04	15.00	PHARMACY	RELATED PARTY	515,465	216,286	4.04
4.05	30.00	ADULTS & PEDIATRICS	RELATED PARTY	145,229	84,011	4.05
4.06	50.00	OPERATING ROOM	RELATED PARTY	239,767	253,048	4.06
4.07	76.00	CARDIOPULMONARY	RELATED PARTY	12,255	36,561	4.07
4.08	91.00	EMERGENCY	RELATED PARTY	178,211	119,709	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	95,121	95,121	4.09
4.10	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	306,480	306,480	4.10
4.11	50.00	OPERATING ROOM	SHARED EMPLOYEES	112,068	112,068	4.11
4.12	60.00	LABORATORY	SHARED EMPLOYEES	1,336,661	1,336,661	4.12
4.13	76.00	CARDIOPULMONARY	SHARED EMPLOYEES	20,800	20,800	4.13
4.14	192.00	PHYSICIANS' PRIVATE OFFICES	SHARED EMPLOYEES	28,625	28,625	4.14
4.15	0.00			0	0	4.15
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,244,521	8,636,745	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:					
6.00	B	IU HEALTH	100.00		0.00	6.00
7.00	B	IUH ARNETT	1.00		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

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.

(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: 15-1312	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/28/2019 6:19 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	34,437	11		1.00
2.00	1,469,635	0		2.00
3.00	46,555	0		3.00
3.01	561,797	0		3.01
3.02	-30,029	0		3.02
4.00	52,192	0		4.00
4.01	-8,380	0		4.01
4.02	78,082	0		4.02
4.03	22,175	0		4.03
4.04	299,179	0		4.04
4.05	61,218	0		4.05
4.06	-13,281	0		4.06
4.07	-24,306	0		4.07
4.08	58,502	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
5.00	2,607,776			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/28/2019 6:19 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	306,480	306,480	0	0	0	1.00
2.00	50.00	OPERATING ROOM	64,443	64,443	0	0	0	2.00
3.00	91.00	EMERGENCY	1,144,711	0	1,144,711	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,515,634	370,923	1,144,711		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	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	306,480		1.00
2.00	50.00	OPERATING ROOM	0	0	0	64,443		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	370,923		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 6:19 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	1.02	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	55,584	55,584				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	2,457,931	0	2,457,931			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	619,334	0	0	619,334		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,486,111	0	0	0	1,486,111	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,274,027	5,211	100,581	108,495	92,093	5.00
7.00	00700	OPERATION OF PLANT	230,995	0	0	0	41,188	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	1,720,214	7,682	560,186	0	0	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	294,897	4,930	0	139,603	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	68,966	247	18,039	0	0	8.00
9.00	00900	HOUSEKEEPING	387,741	825	55,270	1,892	62,245	9.00
10.00	01000	DIETARY	476,672	2,176	0	61,601	85,310	10.00
11.00	01100	CAFETERIA	1,092	613	0	17,363	15,027	11.00
13.00	01300	NURSING ADMINISTRATION	826,183	699	29,537	8,316	138,173	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	649,494	2,187	159,442	0	0	14.00
15.00	01500	PHARMACY	996,546	934	68,094	0	77,461	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,497,875	6,037	440,154	0	234,647	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	790,874	3,956	288,406	0	88,707	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	451,207	1,498	109,216	0	59,515	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	107,707	308	22,442	0	15,276	55.00
56.00	03630	ULTRA SOUND	155,907	212	15,474	0	26,509	56.00
57.00	05700	CT SCAN	414,419	290	21,116	0	73,661	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	121,727	409	29,794	0	21,913	58.00
60.00	06000	LABORATORY	1,372,231	1,360	99,128	0	0	60.00
66.00	06600	PHYSICAL THERAPY	313,236	1,317	96,050	0	55,471	66.00
67.00	06700	OCCUPATIONAL THERAPY	121,738	105	7,652	0	21,693	67.00
68.00	06800	SPEECH PATHOLOGY	74,292	49	3,591	0	13,230	68.00
69.00	06900	ELECTROCARDIOLOGY	107,755	313	22,826	0	18,211	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,626	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,676	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	324,414	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	1,668,014	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	479,408	619	45,140	0	80,718	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	141,375	716	52,235	0	22,099	90.00
91.00	09100	EMERGENCY	2,620,166	2,929	213,558	0	226,217	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,335,434	45,622	2,457,931	337,270	1,469,364	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	92,771	1,748	0	49,500	16,747	192.00
192.02	19202	MOB	0	6,487	0	183,678	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	1,727	0	48,886	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	27,428,205	55,584	2,457,931	619,334	1,486,111	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 6:19 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
			4A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,580,407	6,580,407				5.00
7.00	00700	OPERATION OF PLANT	272,183	85,912	358,095			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	2,288,082	722,210	54,617	3,064,909		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	439,430	138,702	35,050	0	613,182	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	87,252	27,540	1,759	30,764	0	8.00
9.00	00900	HOUSEKEEPING	507,973	160,337	5,864	94,259	3,126	9.00
10.00	01000	DIETARY	625,759	197,515	15,466	0	101,749	10.00
11.00	01100	CAFETERIA	34,095	10,762	4,359	0	28,680	11.00
13.00	01300	NURSING ADMINISTRATION	1,002,908	316,558	4,968	50,373	13,737	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	811,123	256,023	15,545	271,915	0	14.00
15.00	01500	PHARMACY	1,143,035	360,788	6,639	116,129	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,178,713	687,689	42,915	750,644	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,171,943	369,912	28,119	491,852	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	621,436	196,150	10,648	186,258	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	145,733	45,999	2,188	38,272	0	55.00
56.00	03630	ULTRA SOUND	198,102	62,529	1,509	26,390	0	56.00
57.00	05700	CT SCAN	509,486	160,814	2,059	36,012	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	173,843	54,872	2,905	50,811	0	58.00
60.00	06000	LABORATORY	1,472,719	464,849	9,665	169,054	0	60.00
66.00	06600	PHYSICAL THERAPY	466,074	147,112	9,365	163,805	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	151,188	47,721	746	13,049	0	67.00
68.00	06800	SPEECH PATHOLOGY	91,162	28,774	350	6,124	0	68.00
69.00	06900	ELECTROCARDIOLOGY	149,105	47,064	2,226	38,928	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,626	6,510	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,676	2,107	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	324,414	102,398	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	1,668,014	526,492	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	605,885	191,242	4,401	76,982	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	216,425	68,312	5,093	89,083	0	90.00
91.00	09100	EMERGENCY	3,062,870	966,771	20,822	364,205	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,026,661	6,453,664	287,278	3,064,909	147,292	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	160,766	50,744	12,428	0	81,761	192.00
192.02	19202	MOB	190,165	60,024	46,115	0	303,382	192.02
192.03	19203	ARNETT SURGERY OFFICE	50,613	15,975	12,274	0	80,747	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	27,428,205	6,580,407	358,095	3,064,909	613,182	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 6:19 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
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 - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	147,315					8.00
9.00	00900	HOUSEKEEPING	0	771,559				9.00
10.00	01000	DIETARY	0	32,107	972,596			10.00
11.00	01100	CAFETERIA	0	9,174	0	87,070		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	8,260	1,396,804	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,932	0	0	0	14.00
15.00	01500	PHARMACY	0	23,917	0	3,659	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	147,315	197,886	972,596	18,444	755,750	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	86,493	0	5,865	145,683	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,019	0	4,213	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,604	0	776	0	55.00
56.00	03630	ULTRA SOUND	0	2,621	0	1,470	0	56.00
57.00	05700	CT SCAN	0	3,604	0	4,816	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,914	0	1,454	0	58.00
60.00	06000	LABORATORY	0	36,694	0	8,095	0	60.00
66.00	06600	PHYSICAL THERAPY	0	30,797	0	3,535	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,293	0	876	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,311	0	578	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,322	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	31,452	0	5,460	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	22,606	0	1,702	0	90.00
91.00	09100	EMERGENCY	0	108,444	0	15,025	495,371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	147,315	619,868	972,596	85,550	1,396,804	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	32,435	0	1,520	0	192.00
192.02	19202	MOB	0	119,256	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	147,315	771,559	972,596	87,070	1,396,804	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 6:19 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
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 - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
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	1,358,538					14.00
15.00	01500	PHARMACY	43,287	1,697,454				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	183,810	4,734	0	5,940,496	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	282,773	4,330	0	2,586,970	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,211	268	0	1,045,203	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,288	28	0	237,888	0	55.00
56.00	03630	ULTRA SOUND	9,874	0	0	302,495	0	56.00
57.00	05700	CT SCAN	111,375	489	0	828,655	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	32,125	0	0	320,924	0	58.00
60.00	06000	LABORATORY	0	0	0	2,161,076	0	60.00
66.00	06600	PHYSICAL THERAPY	8,058	3	0	828,749	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	389	0	0	216,262	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	128,299	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,116	36	0	246,797	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	198,993	0	0	226,129	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,009	0	0	23,792	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	272,996	0	699,808	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	1,403,645	0	3,598,151	0	73.01
76.00	03160	CARDIOPULMONARY	47,112	72	0	962,606	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,599	1,891	0	416,711	0	90.00
91.00	09100	EMERGENCY	391,510	8,954	0	5,433,972	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,353,529	1,697,446	0	26,204,983	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,009	8	0	344,671	0	192.00
192.02	19202	MOB	0	0	0	718,942	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	159,609	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,358,538	1,697,454	0	27,428,205	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 6:19 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB			1.02
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 - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - TLMOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,940,496		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,586,970		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,045,203		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	237,888		55.00
56.00	03630	ULTRA SOUND	302,495		56.00
57.00	05700	CT SCAN	828,655		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	320,924		58.00
60.00	06000	LABORATORY	2,161,076		60.00
66.00	06600	PHYSICAL THERAPY	828,749		66.00
67.00	06700	OCCUPATIONAL THERAPY	216,262		67.00
68.00	06800	SPEECH PATHOLOGY	128,299		68.00
69.00	06900	ELECTROCARDIOLOGY	246,797		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	226,129		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,792		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	699,808		73.00
73.01	07301	ONCOLOGY DRUGS	3,598,151		73.01
76.00	03160	CARDIOPULMONARY	962,606		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	416,711		90.00
91.00	09100	EMERGENCY	5,433,972		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,204,983		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	344,671		192.00
192.02	19202	MOB	718,942		192.02
192.03	19203	ARNETT SURGERY OFFICE	159,609		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0		192.04
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	27,428,205		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 6:19 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	Subtotal	
			0	1.00	1.01	1.02	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	561,797	5,211	100,581	108,495	776,084	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	7,682	560,186	0	567,868	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	4,930	0	139,603	144,533	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	247	18,039	0	18,286	8.00
9.00	00900	HOUSEKEEPING	0	825	55,270	1,892	57,987	9.00
10.00	01000	DIETARY	0	2,176	0	61,601	63,777	10.00
11.00	01100	CAFETERIA	0	613	0	17,363	17,976	11.00
13.00	01300	NURSING ADMINISTRATION	0	699	29,537	8,316	38,552	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,187	159,442	0	161,629	14.00
15.00	01500	PHARMACY	0	934	68,094	0	69,028	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,037	440,154	0	446,191	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,956	288,406	0	292,362	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,498	109,216	0	110,714	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	308	22,442	0	22,750	55.00
56.00	03630	ULTRA SOUND	0	212	15,474	0	15,686	56.00
57.00	05700	CT SCAN	0	290	21,116	0	21,406	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	409	29,794	0	30,203	58.00
60.00	06000	LABORATORY	0	1,360	99,128	0	100,488	60.00
66.00	06600	PHYSICAL THERAPY	0	1,317	96,050	0	97,367	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	105	7,652	0	7,757	67.00
68.00	06800	SPEECH PATHOLOGY	0	49	3,591	0	3,640	68.00
69.00	06900	ELECTROCARDIOLOGY	0	313	22,826	0	23,139	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	619	45,140	0	45,759	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	716	52,235	0	52,951	90.00
91.00	09100	EMERGENCY	0	2,929	213,558	0	216,487	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	561,797	45,622	2,457,931	337,270	3,402,620	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,748	0	49,500	51,248	192.00
192.02	19202	MOB	0	6,487	0	183,678	190,165	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	1,727	0	48,886	50,613	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	561,797	55,584	2,457,931	619,334	3,694,646	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 6:19 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
			4.00	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	776,084				5.00
7.00	00700	OPERATION OF PLANT	0	10,132	10,132			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	85,176	1,544	654,588		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	16,358	992	0	161,883	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,248	50	6,570	0	8.00
9.00	00900	HOUSEKEEPING	0	18,910	166	20,131	825	9.00
10.00	01000	DIETARY	0	23,295	438	0	26,862	10.00
11.00	01100	CAFETERIA	0	1,269	123	0	7,572	11.00
13.00	01300	NURSING ADMINISTRATION	0	37,334	141	10,759	3,627	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	30,195	440	58,074	0	14.00
15.00	01500	PHARMACY	0	42,551	188	24,802	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	81,105	1,214	160,320	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	43,627	796	105,047	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,134	301	39,780	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,425	62	8,174	0	55.00
56.00	03630	ULTRA SOUND	0	7,375	43	5,636	0	56.00
57.00	05700	CT SCAN	0	18,966	58	7,691	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,471	82	10,852	0	58.00
60.00	06000	LABORATORY	0	54,823	273	36,106	0	60.00
66.00	06600	PHYSICAL THERAPY	0	17,350	265	34,985	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,628	21	2,787	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,394	10	1,308	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,551	63	8,314	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	768	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	249	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,077	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	62,093	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	22,555	125	16,441	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	8,057	144	19,026	0	90.00
91.00	09100	EMERGENCY	0	114,020	589	77,785	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	761,136	8,128	654,588	38,886	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,985	352	0	21,585	192.00
192.02	19202	MOB	0	7,079	1,305	0	80,094	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	1,884	347	0	21,318	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	0	776,084	10,132	654,588	161,883	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 6:19 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
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 - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	28,154					8.00
9.00	00900	HOUSEKEEPING	0	98,019				9.00
10.00	01000	DIETARY	0	4,079	118,451			10.00
11.00	01100	CAFETERIA	0	1,165	0	28,105		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,666	93,079	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	499	0	0	0	14.00
15.00	01500	PHARMACY	0	3,038	0	1,181	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,154	25,141	118,451	5,953	50,361	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,988	0	1,893	9,708	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,289	0	1,360	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	458	0	251	0	55.00
56.00	03630	ULTRA SOUND	0	333	0	475	0	56.00
57.00	05700	CT SCAN	0	458	0	1,554	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	624	0	469	0	58.00
60.00	06000	LABORATORY	0	4,662	0	2,613	0	60.00
66.00	06600	PHYSICAL THERAPY	0	3,912	0	1,141	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	291	0	283	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	166	0	187	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	427	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	3,996	0	1,762	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,872	0	549	0	90.00
91.00	09100	EMERGENCY	0	13,777	0	4,850	33,010	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,154	78,748	118,451	27,614	93,079	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,121	0	491	0	192.00
192.02	19202	MOB	0	15,150	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	28,154	98,019	118,451	28,105	93,079	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 6:19 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
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 - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
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	250,837					14.00
15.00	01500	PHARMACY	7,992	148,780				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,938	415	0	951,243	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,210	379	0	517,010	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,516	24	0	179,118	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	238	2	0	37,360	0	55.00
56.00	03630	ULTRA SOUND	1,823	0	0	31,371	0	56.00
57.00	05700	CT SCAN	20,564	43	0	70,740	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,931	0	0	54,632	0	58.00
60.00	06000	LABORATORY	0	0	0	198,965	0	60.00
66.00	06600	PHYSICAL THERAPY	1,488	0	0	156,508	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	72	0	0	16,839	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	8,705	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,499	3	0	38,996	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,742	0	0	37,510	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,771	0	0	3,020	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,928	0	36,005	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	123,028	0	185,121	0	73.01
76.00	03160	CARDIOPULMONARY	8,699	6	0	99,343	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,142	166	0	85,907	0	90.00
91.00	09100	EMERGENCY	72,287	785	0	533,590	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	249,912	148,779	0	3,241,983	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	925	1	0	84,708	0	192.00
192.02	19202	MOB	0	0	0	293,793	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	74,162	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	250,837	148,780	0	3,694,646	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 6:19 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB			1.02
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 - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - TLMOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	951,243		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	517,010		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	179,118		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	37,360		55.00
56.00	03630	ULTRA SOUND	31,371		56.00
57.00	05700	CT SCAN	70,740		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	54,632		58.00
60.00	06000	LABORATORY	198,965		60.00
66.00	06600	PHYSICAL THERAPY	156,508		66.00
67.00	06700	OCCUPATIONAL THERAPY	16,839		67.00
68.00	06800	SPEECH PATHOLOGY	8,705		68.00
69.00	06900	ELECTROCARDIOLOGY	38,996		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,510		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,020		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,005		73.00
73.01	07301	ONCOLOGY DRUGS	185,121		73.01
76.00	03160	CARDIOPULMONARY	99,343		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	85,907		90.00
91.00	09100	EMERGENCY	533,590		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,241,983		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	84,708		192.00
192.02	19202	MOB	293,793		192.02
192.03	19203	ARNETT SURGERY OFFICE	74,162		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0		192.04
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,694,646		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 6:19 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - HOSPITAL (SQUARE FEET)	BLDG & FIXT - TLMOB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	94,811					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	57,501				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	37,310			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	7,758,020		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,889	2,353	6,536	480,760	-6,580,407	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	215,017	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	13,105	13,105	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	8,410	0	8,410	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	422	422	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,407	1,293	114	324,941	0	9.00
10.00	01000	DIETARY	3,711	0	3,711	445,349	0	10.00
11.00	01100	CAFETERIA	1,046	0	1,046	78,446	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,192	691	501	721,311	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	3,730	0	0	0	14.00
15.00	01500	PHARMACY	1,593	1,593	0	404,373	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,297	10,297	0	1,224,924	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,747	6,747	0	463,082	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,555	2,555	0	310,688	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	525	525	0	79,747	0	55.00
56.00	03630	ULTRA SOUND	362	362	0	138,387	0	56.00
57.00	05700	CT SCAN	494	494	0	384,538	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	697	697	0	114,396	0	58.00
60.00	06000	LABORATORY	2,319	2,319	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	2,247	2,247	0	289,577	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	179	179	0	113,246	0	67.00
68.00	06800	SPEECH PATHOLOGY	84	84	0	69,067	0	68.00
69.00	06900	ELECTROCARDIOLOGY	534	534	0	95,070	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	1,056	1,056	0	421,375	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,222	1,222	0	115,366	0	90.00
91.00	09100	EMERGENCY	4,996	4,996	0	1,180,933	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,819	57,501	20,318	7,670,593	-6,580,407	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,982	0	2,982	87,427	0	192.00
192.02	19202	MOB	11,065	0	11,065	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	2,945	0	2,945	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	55,584	2,457,931	619,334	1,486,111		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.586261	42.745883	16.599678	0.191558		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 6:19 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL (SQUARE FEET)	OPERATION OF PLANT - TLMOB (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
			5.00	7.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,847,798					5.00
7.00	00700	OPERATION OF PLANT	272,183	85,922				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	2,288,082	13,105	42,043			7.01
7.02	00702	OPERATION OF PLANT - TLMOB	439,430	8,410	0	22,364		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	87,252	422	422	0	2,264	8.00
9.00	00900	HOUSEKEEPING	507,973	1,407	1,293	114	0	9.00
10.00	01000	DIETARY	625,759	3,711	0	3,711	0	10.00
11.00	01100	CAFETERIA	34,095	1,046	0	1,046	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,002,908	1,192	691	501	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	811,123	3,730	3,730	0	0	14.00
15.00	01500	PHARMACY	1,143,035	1,593	1,593	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,178,713	10,297	10,297	0	2,264	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,171,943	6,747	6,747	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	621,436	2,555	2,555	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	145,733	525	525	0	0	55.00
56.00	03630	ULTRA SOUND	198,102	362	362	0	0	56.00
57.00	05700	CT SCAN	509,486	494	494	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	173,843	697	697	0	0	58.00
60.00	06000	LABORATORY	1,472,719	2,319	2,319	0	0	60.00
66.00	06600	PHYSICAL THERAPY	466,074	2,247	2,247	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	151,188	179	179	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	91,162	84	84	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	149,105	534	534	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,626	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,676	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	324,414	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	1,668,014	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	605,885	1,056	1,056	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	216,425	1,222	1,222	0	0	90.00
91.00	09100	EMERGENCY	3,062,870	4,996	4,996	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,446,254	68,930	42,043	5,372	2,264	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	160,766	2,982	0	2,982	0	192.00
192.02	19202	MOB	190,165	11,065	0	11,065	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	50,613	2,945	0	2,945	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	6,580,407	358,095	3,064,909	613,182	147,315	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.315640	4.167675	72.899389	27.418261	65.068463	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	776,084	10,132	654,588	161,883	28,154	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.037226	0.117921	15.569488	7.238553	12.435512	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: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 6:19 pm

		Cost Center Description	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			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 - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
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 - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	2,355					9.00
10.00	01000	DIETARY	98	2,264				10.00
11.00	01100	CAFETERIA	28	0	10,541			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,000	74,604		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12	0	0	0	604,271	14.00
15.00	01500	PHARMACY	73	0	443	0	19,254	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	604	2,264	2,233	40,365	81,758	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	264	0	710	7,781	125,776	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55	0	510	0	3,652	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11	0	94	0	573	55.00
56.00	03630	ULTRA SOUND	8	0	178	0	4,392	56.00
57.00	05700	CT SCAN	11	0	583	0	49,539	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15	0	176	0	14,289	58.00
60.00	06000	LABORATORY	112	0	980	0	0	60.00
66.00	06600	PHYSICAL THERAPY	94	0	428	0	3,584	66.00
67.00	06700	OCCUPATIONAL THERAPY	7	0	106	0	173	67.00
68.00	06800	SPEECH PATHOLOGY	4	0	70	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	160	0	3,610	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	88,511	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,676	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	96	0	661	0	20,955	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	69	0	206	0	5,159	90.00
91.00	09100	EMERGENCY	331	0	1,819	26,458	174,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,892	2,264	10,357	74,604	602,043	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	99	0	184	0	2,228	192.00
192.02	19202	MOB	364	0	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	771,559	972,596	87,070	1,396,804	1,358,538	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	327.625902	429.591873	8.260127	18.722910	2.248226	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	98,019	118,451	28,105	93,079	250,837	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	41.621656	52.319346	2.666256	1.247641	0.415107	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: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 6:19 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			15.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB				1.02
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 - HOSPITAL				7.01
7.02	00702	OPERATION OF PLANT - TLMOB				7.02
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	2,017,161			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	5,626	0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	5,145	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	319	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	33	0		55.00
56.00	03630	ULTRA SOUND	0	0		56.00
57.00	05700	CT SCAN	581	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	4	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	43	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	324,414	0		73.00
73.01	07301	ONCOLOGY DRUGS	1,668,014	0		73.01
76.00	03160	CARDIOPULMONARY	85	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2,247	0		90.00
91.00	09100	EMERGENCY	10,641	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,017,152	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9	0		192.00
192.02	19202	MOB	0	0		192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0		192.04
193.00	19300	NONPAID WORKERS	0	0		193.00
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)	1,697,454	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.841506	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	148,780	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.073757	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 6:19 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	5,940,496		5,940,496	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,586,970		2,586,970	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,045,203		1,045,203	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	237,888		237,888	0	0	55.00
56.00	03630	ULTRA SOUND	302,495		302,495	0	0	56.00
57.00	05700	CT SCAN	828,655		828,655	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	320,924		320,924	0	0	58.00
60.00	06000	LABORATORY	2,161,076		2,161,076	0	0	60.00
66.00	06600	PHYSICAL THERAPY	828,749	0	828,749	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	216,262	0	216,262	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	128,299	0	128,299	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	246,797		246,797	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	226,129		226,129	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,792		23,792	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	699,808		699,808	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	3,598,151		3,598,151	0	0	73.01
76.00	03160	CARDIOPULMONARY	962,606		962,606	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	416,711		416,711	0	0	90.00
91.00	09100	EMERGENCY	5,433,972		5,433,972	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,056,146		1,056,146		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	27,261,129	0	27,261,129	0	0	200.00
201.00		Less Observation Beds	1,056,146		1,056,146		0	201.00
202.00		Total (see instructions)	26,204,983	0	26,204,983	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 6:19 pm

Title XVIII | 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	4,396,365		4,396,365			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,165,676	6,165,676	0.419576	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,212	4,988,178	5,055,390	0.206750	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	974,048	974,048	0.244226	0.000000	55.00
56.00	03630	ULTRA SOUND	140,872	2,247,880	2,388,752	0.126633	0.000000	56.00
57.00	05700	CT SCAN	195,291	4,601,700	4,796,991	0.172745	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	66,687	1,465,054	1,531,741	0.209516	0.000000	58.00
60.00	06000	LABORATORY	809,566	5,367,134	6,176,700	0.349875	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	392,797	1,246,936	1,639,733	0.505417	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	176,253	212,878	389,131	0.555756	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	28,368	178,833	207,201	0.619201	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,337,267	1,337,267	0.184553	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,024	549,187	558,211	0.405096	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	110,178	110,178	0.215941	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,660,351	3,831,814	5,492,165	0.127419	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	7,211,870	7,211,870	0.498921	0.000000	73.01
76.00	03160	CARDIOPULMONARY	803,498	2,784,746	3,588,244	0.268267	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,242,630	1,242,630	0.335346	0.000000	90.00
91.00	09100	EMERGENCY	496,959	23,913,495	24,410,454	0.222608	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,561	3,368,690	3,383,251	0.312169	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	9,257,804	71,798,194	81,055,998			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,257,804	71,798,194	81,055,998			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 6:19 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
56.00	03630	ULTRA SOUND	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
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: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 6:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,940,496		5,940,496	0	5,940,496	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,586,970		2,586,970	0	2,586,970	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,045,203		1,045,203	0	1,045,203	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	237,888		237,888	0	237,888	55.00
56.00	03630	ULTRA SOUND	302,495		302,495	0	302,495	56.00
57.00	05700	CT SCAN	828,655		828,655	0	828,655	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	320,924		320,924	0	320,924	58.00
60.00	06000	LABORATORY	2,161,076		2,161,076	0	2,161,076	60.00
66.00	06600	PHYSICAL THERAPY	828,749	0	828,749	0	828,749	66.00
67.00	06700	OCCUPATIONAL THERAPY	216,262	0	216,262	0	216,262	67.00
68.00	06800	SPEECH PATHOLOGY	128,299	0	128,299	0	128,299	68.00
69.00	06900	ELECTROCARDIOLOGY	246,797		246,797	0	246,797	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	226,129		226,129	0	226,129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,792		23,792	0	23,792	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	699,808		699,808	0	699,808	73.00
73.01	07301	ONCOLOGY DRUGS	3,598,151		3,598,151	0	3,598,151	73.01
76.00	03160	CARDIOPULMONARY	962,606		962,606	0	962,606	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	416,711		416,711	0	416,711	90.00
91.00	09100	EMERGENCY	5,433,972		5,433,972	0	5,433,972	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,056,146		1,056,146		1,056,146	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	27,261,129	0	27,261,129	0	27,261,129	200.00
201.00		Less Observation Beds	1,056,146		1,056,146		1,056,146	201.00
202.00		Total (see instructions)	26,204,983	0	26,204,983	0	26,204,983	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 6:19 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	4,396,365		4,396,365			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,165,676	6,165,676	0.419576	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,212	4,988,178	5,055,390	0.206750	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	974,048	974,048	0.244226	0.000000	55.00
56.00	03630	ULTRA SOUND	140,872	2,247,880	2,388,752	0.126633	0.000000	56.00
57.00	05700	CT SCAN	195,291	4,601,700	4,796,991	0.172745	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	66,687	1,465,054	1,531,741	0.209516	0.000000	58.00
60.00	06000	LABORATORY	809,566	5,367,134	6,176,700	0.349875	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	392,797	1,246,936	1,639,733	0.505417	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	176,253	212,878	389,131	0.555756	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	28,368	178,833	207,201	0.619201	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,337,267	1,337,267	0.184553	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,024	549,187	558,211	0.405096	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	110,178	110,178	0.215941	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,660,351	3,831,814	5,492,165	0.127419	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	7,211,870	7,211,870	0.498921	0.000000	73.01
76.00	03160	CARDIOPULMONARY	803,498	2,784,746	3,588,244	0.268267	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,242,630	1,242,630	0.335346	0.000000	90.00
91.00	09100	EMERGENCY	496,959	23,913,495	24,410,454	0.222608	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,561	3,368,690	3,383,251	0.312169	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	9,257,804	71,798,194	81,055,998			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,257,804	71,798,194	81,055,998			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 6:19 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
56.00	03630	ULTRA SOUND	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
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: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/28/2019 6:19 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	517,010	6,165,676	0.083853	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	179,118	5,055,390	0.035431	29,252	1,036	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	37,360	974,048	0.038355	0	0	55.00
56.00	03630	ULTRA SOUND	31,371	2,388,752	0.013133	66,687	876	56.00
57.00	05700	CT SCAN	70,740	4,796,991	0.014747	35,567	525	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	54,632	1,531,741	0.035667	23,263	830	58.00
60.00	06000	LABORATORY	198,965	6,176,700	0.032212	434,394	13,993	60.00
66.00	06600	PHYSICAL THERAPY	156,508	1,639,733	0.095447	132,859	12,681	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,839	389,131	0.043273	50,219	2,173	67.00
68.00	06800	SPEECH PATHOLOGY	8,705	207,201	0.042012	14,357	603	68.00
69.00	06900	ELECTROCARDIOLOGY	38,996	1,337,267	0.029161	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,510	558,211	0.067197	4,893	329	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,020	110,178	0.027410	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,005	5,492,165	0.006556	867,362	5,686	73.00
73.01	07301	ONCOLOGY DRUGS	185,121	7,211,870	0.025669	0	0	73.01
76.00	03160	CARDIOPULMONARY	99,343	3,588,244	0.027686	455,404	12,608	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	85,907	1,242,630	0.069133	0	0	90.00
91.00	09100	EMERGENCY	533,590	24,410,454	0.021859	8,835	193	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	169,120	3,383,251	0.049987	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
200.00		Total (lines 50 through 199)	2,459,860	76,659,633		2,123,092	51,533	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 6:19 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
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: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 6:19 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	6,165,676	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,055,390	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	974,048	0.000000	55.00
56.00	03630	ULTRA SOUND	0	0	0	2,388,752	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	4,796,991	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,531,741	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	6,176,700	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,639,733	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	389,131	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	207,201	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,337,267	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	558,211	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	110,178	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,492,165	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	7,211,870	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	3,588,244	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,242,630	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,410,454	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,383,251	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
200.00		Total (lines 50 through 199)	0	0	0	76,659,633		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 6:19 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	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	29,252	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0.000000	66,687	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	35,567	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	23,263	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	434,394	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	132,859	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	50,219	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	14,357	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	4,893	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	867,362	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.000000	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	455,404	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	8,835	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		2,123,092	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 6:19 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	0.419576	0	2,171,670	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.206750	0	1,273,883	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.244226	0	460,804	0	0	55.00
56.00	03630	ULTRA SOUND	0.126633	0	884,425	0	0	56.00
57.00	05700	CT SCAN	0.172745	0	1,816,719	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.209516	0	564,617	0	0	58.00
60.00	06000	LABORATORY	0.349875	0	2,086,623	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.505417	0	500,930	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.555756	0	60,268	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.619201	0	21,223	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184553	0	490,711	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.405096	0	172,756	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.215941	0	37,084	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.127419	0	1,500,896	3,538	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.498921	0	5,301,149	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.268267	0	1,184,748	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.335346	0	810,743	0	0	90.00
91.00	09100	EMERGENCY	0.222608	0	6,700,093	2,161	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.312169	0	1,669,836	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Subtotal (see instructions)		0	27,709,178	5,699	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	27,709,178	5,699	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 6:19 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	911,181	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	263,375	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	112,540	0		55.00
56.00	03630	ULTRA SOUND	111,997	0		56.00
57.00	05700	CT SCAN	313,829	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	118,296	0		58.00
60.00	06000	LABORATORY	730,057	0		60.00
66.00	06600	PHYSICAL THERAPY	253,179	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	33,494	0		67.00
68.00	06800	SPEECH PATHOLOGY	13,141	0		68.00
69.00	06900	ELECTROCARDIOLOGY	90,562	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	69,983	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,008	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	191,243	451		73.00
73.01	07301	ONCOLOGY DRUGS	2,644,855	0		73.01
76.00	03160	CARDIOPULMONARY	317,829	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	271,879	0		90.00
91.00	09100	EMERGENCY	1,491,494	481		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	521,271	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00		Subtotal (see instructions)	8,468,213	932		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,468,213	932		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1312 | Component CCN: 15-Z312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 6:19 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	0.419576	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.206750	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.244226	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0.126633	0	0	0	0	56.00
57.00	05700	CT SCAN	0.172745	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.209516	0	0	0	0	58.00
60.00	06000	LABORATORY	0.349875	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.505417	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.555756	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.619201	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184553	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.405096	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.215941	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.127419	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.498921	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.268267	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.335346	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.222608	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.312169	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
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: 15-1312 | Component CCN: 15-Z312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/28/2019 6:19 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	03630	ULTRA SOUND	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	ONCOLOGY DRUGS	0	0		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
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: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 6:19 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	0.419576	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.206750	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.244226	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0.126633	0	0	0	0	56.00
57.00	05700	CT SCAN	0.172745	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.209516	0	0	0	0	58.00
60.00	06000	LABORATORY	0.349875	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.505417	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.555756	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.619201	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184553	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.405096	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.215941	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.127419	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.498921	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.268267	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.335346	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.222608	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.312169	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
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: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 6:19 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	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	03630	ULTRA SOUND	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 6:19 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)	2,710	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,178	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)	1,732	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	319	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	213	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)	1,147	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)	319	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)	5,940,496	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)	27,507	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)	782,912	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,157,584	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)	5,157,584	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,368.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,716,142	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)	2,716,142	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 6:19 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)	518,081	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,234,223	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)	755,405	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)	755,405	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)	446	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,368.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,056,146	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 6:19 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	951,243	5,940,496	0.160129	1,056,146	169,120	90.00
91.00	Nursing School cost	0	5,940,496	0.000000	1,056,146	0	91.00
92.00	Allied health cost	0	5,940,496	0.000000	1,056,146	0	92.00
93.00	All other Medical Education	0	5,940,496	0.000000	1,056,146	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 6:19 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)	2,710	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,178	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)	1,732	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	319	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	213	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)	7	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,940,496	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)	27,507	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)	782,912	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,157,584	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)	5,157,584	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,368.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	16,576	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)	16,576	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 6:19 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)	6,496	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	23,072	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	446	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,368.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,056,146	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 6:19 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	951,243	5,940,496	0.160129	1,056,146	169,120	90.00
91.00	Nursing School cost	0	5,940,496	0.000000	1,056,146	0	91.00
92.00	Allied health cost	0	5,940,496	0.000000	1,056,146	0	92.00
93.00	All other Medical Education	0	5,940,496	0.000000	1,056,146	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 6:19 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		2,386,602		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.419576	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.206750	29,252	6,048	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.244226	0	0	55.00
56.00	03630	ULTRA SOUND	0.126633	66,687	8,445	56.00
57.00	05700	CT SCAN	0.172745	35,567	6,144	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.209516	23,263	4,874	58.00
60.00	06000	LABORATORY	0.349875	434,394	151,984	60.00
66.00	06600	PHYSICAL THERAPY	0.505417	132,859	67,149	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.555756	50,219	27,910	67.00
68.00	06800	SPEECH PATHOLOGY	0.619201	14,357	8,890	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184553	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.405096	4,893	1,982	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.215941	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.127419	867,362	110,518	73.00
73.01	07301	ONCOLOGY DRUGS	0.498921	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.268267	455,404	122,170	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.335346	0	0	90.00
91.00	09100	EMERGENCY	0.222608	8,835	1,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.312169	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,123,092	518,081	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,123,092		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3

Component CCN: 15-Z312 | Date/Time Prepared: 5/28/2019 6:19 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	0.419576	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.206750	3,626	750	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.244226	0	0	55.00
56.00	03630	ULTRA SOUND	0.126633	7,114	901	56.00
57.00	05700	CT SCAN	0.172745	9,964	1,721	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.209516	2,938	616	58.00
60.00	06000	LABORATORY	0.349875	36,883	12,904	60.00
66.00	06600	PHYSICAL THERAPY	0.505417	135,272	68,369	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.555756	70,594	39,233	67.00
68.00	06800	SPEECH PATHOLOGY	0.619201	7,104	4,399	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184553	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.405096	460	186	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.215941	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.127419	136,112	17,343	73.00
73.01	07301	ONCOLOGY DRUGS	0.498921	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.268267	49,019	13,150	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.335346	0	0	90.00
91.00	09100	EMERGENCY	0.222608	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.312169	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		459,086	159,572	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)		459,086		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 6:19 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		14,608		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.419576	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.206750	468	97	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.244226	0	0	55.00
56.00	03630	ULTRA SOUND	0.126633	0	0	56.00
57.00	05700	CT SCAN	0.172745	2,199	380	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.209516	1,469	308	58.00
60.00	06000	LABORATORY	0.349875	7,415	2,594	60.00
66.00	06600	PHYSICAL THERAPY	0.505417	988	499	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.555756	434	241	67.00
68.00	06800	SPEECH PATHOLOGY	0.619201	532	329	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184553	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.405096	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.215941	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.127419	2,383	304	73.00
73.01	07301	ONCOLOGY DRUGS	0.498921	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.268267	213	57	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.335346	0	0	90.00
91.00	09100	EMERGENCY	0.222608	7,579	1,687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.312169	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		23,680	6,496	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)		23,680		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1312	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 6:19 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,469,145	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)	8,469,145	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)	8,553,836	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)	59,033	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,060,241	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)	3,434,562	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)	3,434,562	30.00
31.00	Primary payer payments	160	31.00
32.00	Subtotal (line 30 minus line 31)	3,434,402	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)	677,364	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	440,287	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	526,516	36.00
37.00	Subtotal (see instructions)	3,874,689	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)	3,874,689	40.00
40.01	Sequestration adjustment (see instructions)	77,494	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,662,330	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	134,865	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	342,726	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: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/28/2019 6:19 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		2,511,749		3,545,130	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	08/08/2018	207,600	05/31/2018	117,200	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)		207,600		117,200	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)		2,719,349		3,662,330	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		165,330		134,865	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,884,679		3,797,195	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: 15-1312 | Component CCN: 15-Z312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2019 6:19 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		732,528		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	08/08/2018	73,000		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)		73,000		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)		805,528		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		97,325		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		902,853		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: 15-1312	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/28/2019 6:19 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: 15-1312 | Component CCN: 15-Z312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 5/28/2019 6:19 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)	762,959	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)	161,168	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	319	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)	924,127	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	924,127	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)	924,127	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,848	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)	921,279	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)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	921,279	0	19.00
19.01	Sequestration adjustment (see instructions)	18,426	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	805,528	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)	97,325	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	37,160	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: 15-1312	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/28/2019 6:19 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,234,223	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)	3,234,223	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,266,565	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)	3,266,565	19.00
20.00	Deductibles (exclude professional component)	340,264	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,926,301	22.00
23.00	Coinsurance	3,350	23.00
24.00	Subtotal (line 22 minus line 23)	2,922,951	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	31,690	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	20,599	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	5,397	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,943,550	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)	2,943,550	30.00
30.01	Sequestration adjustment (see instructions)	58,871	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	2,719,349	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)	165,330	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	131,354	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/28/2019 6:19 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	25,582,113	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	2,065,307	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	256,445	0	0	0	7.00
8.00	Prepaid expenses	73,630	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)	27,977,495	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	972,779	0	0	0	12.00
13.00	Land improvements	122,178	0	0	0	13.00
14.00	Accumulated depreciation	-85,007	0	0	0	14.00
15.00	Buildings	30,277,094	0	0	0	15.00
16.00	Accumulated depreciation	-5,809,935	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,083,124	0	0	0	23.00
24.00	Accumulated depreciation	-5,892,655	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)	29,667,578	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	169,526	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	169,526	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	57,814,599	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,135,635	0	0	0	37.00
38.00	Salaries, wages, and fees payable	751,130	0	0	0	38.00
39.00	Payroll taxes payable	39,235	0	0	0	39.00
40.00	Notes and loans payable (short term)	620,000	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	4,816,465	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,362,465	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	20,315,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	30,459	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20,345,459	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	29,707,924	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	28,106,675				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)	28,106,675	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	57,814,599	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/28/2019 6:19 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		27,607,727		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		338,715				2.00
3.00	Total (sum of line 1 and line 2)		27,946,442		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	NET INTERCOMPANY TRANSACTIONS	160,236		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		160,236		0		10.00
11.00	Subtotal (line 3 plus line 10)		28,106,678		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ROUNDING	3		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		3		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		28,106,675		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	NET INTERCOMPANY TRANSACTIONS		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	ROUNDING		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/28/2019 6:19 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,972,038		3,972,038	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	424,327		424,327	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)	4,396,365		4,396,365	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)	4,396,365		4,396,365	17.00
18.00	Ancillary services	4,349,919	43,273,379	47,623,298	18.00
19.00	Outpatient services	511,520	28,524,815	29,036,335	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,257,804	71,798,194	81,055,998	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,114,927		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)		28,114,927		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/28/2019 6:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	81,055,998	1.00
2.00	Less contractual allowances and discounts on patients' accounts	53,888,420	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,167,578	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,114,927	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-947,349	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	1,286,064	24.00
25.00	Total other income (sum of lines 6-24)	1,286,064	25.00
26.00	Total (line 5 plus line 25)	338,715	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)	338,715	29.00