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: 15-0165	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/31/2019 10:59 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/31/2019 Time: 10:59 am
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 FRANCISCAN HEALTH MUNSTER (15-0165) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	79,377	164,632	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	79,377	164,632	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0165	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/31/2019 10:59 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 701 SUPERIOR STREET	PO Box:			1.00
2.00	City: MUNSTER	State: IN	Zip Code: 46321	County: LAKE	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	FRANCISCAN HEALTH MUNSTER	150165	23844	1	06/01/2007	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	1		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,047	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2019 10:59 am

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2019 10:59 am

		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: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2019 10:59 am

		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: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2019 10:59 am

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

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	232,922	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2019 10:59 am

	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: FRANCISCAN ALLIANCE,	Contractor's Name: WISCONSIN PHYSICIAN SERVICE	Contractor's Number: 8001	141.00
142.00	Street: 1515 DRAGOON TRAIL	PO Box:		142.00
143.00	City: MISHAWAKA	State:	Zip Code: 46546	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)	9.99	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)	07/03/2018	09/30/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2019 10:59 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/16/2019	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y	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	05/29/2019	Y	05/29/2019	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: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2019 10:59 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MATTHEW		DEETS		41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN ST. MARGARET HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	219-932-2300 X33148		MATTHEW.DEETS@FRANCISCANALLIANCE.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0165	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/31/2019 10:59 am

		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.	SR. ANALYST		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: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2019 10:59 am

	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	54	19,710	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		54	19,710	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	9	3,285	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		63	22,995	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		63				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: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2019 10:59 am

	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)	4,641	877	9,858			1.00
2.00	HMO and other (see instructions)	2,397	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,641	877	9,858			7.00
8.00	INTENSIVE CARE UNIT	575	170	1,599			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)	5,216	1,047	11,457	0.00	434.93	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	434.93	27.00
28.00	Observation Bed Days		0	0			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: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2019 10:59 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,167	247	2,616	1.00
2.00	HMO and other (see instructions)			456	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,167	247	2,616	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2019 10:59 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	35,171,584	0	35,171,584	1,079,384.00	32.58	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		5,121,983	0	5,121,983	174,736.00	29.31	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,348,256	0	1,348,256	31,082.00	43.38	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		689,249	0	689,249	10,287.30	67.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		88,520	0	88,520	649.00	136.39	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		5,631,156	0	5,631,156	174,736.00	32.23	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,876,013	0	7,876,013			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		136,855	0	136,855			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		2,127,457	0	2,127,457			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	495,848	0	495,848	6,788.25	73.05	26.00
27.00	Administrative & General	5.00	8,213,163	0	8,213,163	279,259.78	29.41	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II | Date/Time Prepared: 5/31/2019 10:59 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		163,253	0	163,253	1,767.00	92.39	28.00
29.00	Maintenance & Repairs	6.00	548,912	0	548,912	18,439.83	29.77	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	593,651	0	593,651	46,452.33	12.78	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	506,595	0	506,595	34,907.43	14.51	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,229,021	0	1,229,021	29,009.54	42.37	38.00
39.00	Central Services and Supply	14.00	255,479	0	255,479	14,271.29	17.90	39.00
40.00	Pharmacy	15.00	979,137	0	979,137	21,243.25	46.09	40.00
41.00	Medical Records & Medical Records Library	16.00	255,043	0	255,043	6,590.00	38.70	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 5/31/2019 10:59 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		30,212,854	0	30,212,854	906,415.00	33.33	1.00
2.00	Excluded area salaries (see instructions)		1,348,256	0	1,348,256	31,082.00	43.38	2.00
3.00	Subtotal salaries (line 1 minus line 2)		28,864,598	0	28,864,598	875,333.00	32.98	3.00
4.00	Subtotal other wages & related costs (see inst.)		6,408,925	0	6,408,925	185,672.30	34.52	4.00
5.00	Subtotal wage-related costs (see inst.)		10,003,470	0	10,003,470	0.00	34.66	5.00
6.00	Total (sum of lines 3 thru 5)		45,276,993	0	45,276,993	1,061,005.30	42.67	6.00
7.00	Total overhead cost (see instructions)		13,240,102	0	13,240,102	458,728.70	28.86	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 5/31/2019 10:59 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	654,187	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	665,000	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	4,205,213	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	40,470	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	13,002	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	248,310	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	249,863	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,913,190	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	23,612	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	21	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,012,868	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 5/31/2019 10:59 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/31/2019 10:59 am

		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)	0.226155	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,294,650	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	43,626,619	6.00
7.00	Medicaid cost (line 1 times line 6)	9,866,378	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)	1,571,728	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)	1,571,728	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,300,238	4,561,460	7,861,698	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	746,365	4,561,460	5,307,825	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	746,365	4,561,460	5,307,825	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,912,540	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	242,007	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	372,318	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,540,222	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	478,640	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	5,786,465	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,358,193	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/31/2019 10:59 am

		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		7,695,596	7,695,596	-1,033,388	6,662,208	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	495,848	8,226,065	8,721,913	-25,771	8,696,142	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,213,163	9,395,024	17,608,187	13,911	17,622,098	5.00
6.00	00600	MAINTENANCE & REPAIRS	548,912	2,479,444	3,028,356	-7,830	3,020,526	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	93,238	93,238	0	93,238	8.00
9.00	00900	HOUSEKEEPING	593,651	235,911	829,562	-5,079	824,483	9.00
10.00	01000	DIETARY	506,595	381,892	888,487	-47,026	841,461	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,229,021	223,754	1,452,775	-29,978	1,422,797	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	255,479	269,809	525,288	-88,531	436,757	14.00
15.00	01500	PHARMACY	979,137	2,787,072	3,766,209	-2,187,961	1,578,248	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	255,043	11,082	266,125	0	266,125	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,170,786	829,257	7,000,043	-268,393	6,731,650	30.00
31.00	03100	INTENSIVE CARE UNIT	1,382,916	128,457	1,511,373	-96,320	1,415,053	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,565,718	9,289,125	12,854,843	-7,265,445	5,589,398	50.00
51.00	05100	RECOVERY ROOM	1,209,929	169,094	1,379,023	-157,904	1,221,119	51.00
53.00	05300	ANESTHESIOLOGY	30,417	248,299	278,716	-116,960	161,756	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,738,180	744,146	2,482,326	-353,334	2,128,992	54.00
57.00	05700	CT SCAN	510,791	595,879	1,106,670	-118,104	988,566	57.00
58.00	05800	MRI	720,917	879,010	1,599,927	-146,615	1,453,312	58.00
59.00	05900	CARDIAC CATHETERIZATION	854,761	2,186,058	3,040,819	-1,937,797	1,103,022	59.00
60.00	06000	LABORATORY	0	3,825,669	3,825,669	-313,060	3,512,609	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	678,162	135,316	813,478	-78,791	734,687	65.00
66.00	06600	PHYSICAL THERAPY	305,906	1,761	307,667	-6	307,661	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,354	2,025	101,379	-1,454	99,925	67.00
68.00	06800	SPEECH PATHOLOGY	38,351	736	39,087	0	39,087	68.00
69.00	06900	ELECTROCARDIOLOGY	283,756	44,424	328,180	-12,244	315,936	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	431,194	865,344	1,296,538	-78,942	1,217,596	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,642,316	3,642,316	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,387,713	7,387,713	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,566,632	2,566,632	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	185,516	9,761	195,277	-1,247	194,030	76.01
76.02	03952	WOUND CARE	79,264	20,591	99,855	-19,951	79,904	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	578,802	53,198	632,000	-7,250	624,750	90.01
90.02	09002	CLINIC	392,942	309,308	702,250	-74,625	627,625	90.02
91.00	09100	EMERGENCY	1,488,817	746,948	2,235,765	-207,778	2,027,987	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		-1,071,212	-1,071,212	1,071,212	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,823,328	51,812,081	85,635,409	0	85,635,409	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	53,063	27,486	80,549	0	80,549	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,285,291	353,570	1,638,861	0	1,638,861	192.00
192.01	19201	CENTER OF HOPE	9,902	0	9,902	0	9,902	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	35,171,584	52,193,137	87,364,721	0	87,364,721	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/31/2019 10:59 am

		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	-2,694,967	3,967,241		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	42,696	8,738,838		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	721,993	18,344,091		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	3,020,526		6.00
7.00	00700	OPERATION OF PLANT	0	0		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	93,238		8.00
9.00	00900	HOUSEKEEPING	0	824,483		9.00
10.00	01000	DIETARY	-24,953	816,508		10.00
11.00	01100	CAFETERIA	-282,886	-282,886		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	1,422,797		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	436,757		14.00
15.00	01500	PHARMACY	154,091	1,732,339		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	760,476	1,026,601		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-900	6,730,750		30.00
31.00	03100	INTENSIVE CARE UNIT	-5,650	1,409,403		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-605,027	4,984,371		50.00
51.00	05100	RECOVERY ROOM	0	1,221,119		51.00
53.00	05300	ANESTHESIOLOGY	0	161,756		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-5,188	2,123,804		54.00
57.00	05700	CT SCAN	-5,675	982,891		57.00
58.00	05800	MRI	-12,584	1,440,728		58.00
59.00	05900	CARDIAC CATHETERIZATION	-882	1,102,140		59.00
60.00	06000	LABORATORY	-11,090	3,501,519		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
64.01	06401	INTRAVENOUS THERAPY	0	0		64.01
65.00	06500	RESPIRATORY THERAPY	0	734,687		65.00
66.00	06600	PHYSICAL THERAPY	0	307,661		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	99,925		67.00
68.00	06800	SPEECH PATHOLOGY	0	39,087		68.00
69.00	06900	ELECTROCARDIOLOGY	0	315,936		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-6,888	1,210,708		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,642,316		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,387,713		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,566,632		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	-938	193,092		76.01
76.02	03952	WOUND CARE	0	79,904		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	624,750		90.01
90.02	09002	CLINIC	-8,438	619,187		90.02
91.00	09100	EMERGENCY	0	2,027,987		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,986,810	83,648,599		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	80,549		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,638,861		192.00
192.01	19201	CENTER OF HOPE	0	9,902		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,986,810	85,377,911		200.00

RECLASSIFICATIONS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/31/2019 10:59 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	52,101		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	14,277		2.00
	0		0	66,378		
	B - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	1,071,212		1.00
	0		0	1,071,212		
	C - DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,566,632		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
	0		0	2,566,632		
	D - MED SUPPLIES EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	11,030,029		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
	0		0	11,030,029		
	E - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	7,387,713		1.00
	0		0	7,387,713		
500.00	Grand Total: Increases		0	22,121,964		500.00

RECLASSIFICATIONS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/31/2019 10:59 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INSURANCE						
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	52,101	9		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	14,277	9		2.00
	0		0	66,378			
	B - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,071,212	11		1.00
	0		0	1,071,212			
	C - DRUG EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	23,838	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	626	0		2.00
3.00	PHARMACY	15.00	0	2,181,072	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	95	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	16	0		5.00
6.00	OPERATING ROOM	50.00	0	5,297	0		6.00
7.00	RECOVERY ROOM	51.00	0	180	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	27,364	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	312,169	0		9.00
10.00	CT SCAN	57.00	0	14	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	144	0		11.00
12.00	WOUND CARE	76.02	0	7,322	0		12.00
13.00	CLINIC	90.01	0	2,480	0		13.00
14.00	CLINIC	90.02	0	6,014	0		14.00
15.00	EMERGENCY	91.00	0	1	0		15.00
	0		0	2,566,632			
	D - MED SUPPLIES EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,933	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	366	0		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	7,830	0		3.00
4.00	HOUSEKEEPING	9.00	0	5,079	0		4.00
5.00	DIETARY	10.00	0	47,026	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	29,352	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	88,531	0		7.00
8.00	PHARMACY	15.00	0	6,889	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	268,298	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	96,304	0		10.00
11.00	OPERATING ROOM	50.00	0	7,260,148	0		11.00
12.00	RECOVERY ROOM	51.00	0	157,724	0		12.00
13.00	ANESTHESIOLOGY	53.00	0	89,596	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	41,165	0		14.00
15.00	CT SCAN	57.00	0	118,090	0		15.00
16.00	MRI	58.00	0	146,615	0		16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	1,937,653	0		17.00
18.00	LABORATORY	60.00	0	313,060	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	78,791	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	6	0		20.00
21.00	OCCUPATIONAL THERAPY	67.00	0	1,454	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	12,244	0		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	26,841	0		23.00
24.00	CARDIAC AND PULMONARY REHAB	76.01	0	1,247	0		24.00
25.00	WOUND CARE	76.02	0	12,629	0		25.00
26.00	CLINIC	90.01	0	4,770	0		26.00
27.00	CLINIC	90.02	0	68,611	0		27.00
28.00	EMERGENCY	91.00	0	207,777	0		28.00
	0		0	11,030,029			
	E - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	7,387,713	0		1.00
	0		0	7,387,713			
500.00	Grand Total: Decreases		0	22,121,964			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I Date/Time Prepared: 5/31/2019 10:59 am

		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	7,941,227	0	0	0	0	1.00
2.00	Land Improvements	2,653,813	36,482	0	36,482	0	2.00
3.00	Buildings and Fixtures	49,751,780	30,595,559	0	30,595,559	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	76,420,922	26,993,542	0	26,993,542	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	136,767,742	57,625,583	0	57,625,583	0	8.00
9.00	Reconciling Items	-35,527,364	0	0	0	-33,945,404	9.00
10.00	Total (line 8 minus line 9)	172,295,106	57,625,583	0	57,625,583	33,945,404	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	7,941,227	0	1.00
2.00	Land Improvements	2,690,295	0	2.00
3.00	Buildings and Fixtures	80,347,339	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	103,414,464	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	194,393,325	0	8.00
9.00	Reconciling Items	-1,581,960	0	9.00
10.00	Total (line 8 minus line 9)	195,975,285	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II Date/Time Prepared: 5/31/2019 10:59 am

	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	7,695,596	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,695,596	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	7,695,596		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	7,695,596		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2019 10:59 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	7,695,596	0	7,695,596	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	7,695,596	0	7,695,596	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	4,097,548	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,097,548	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	-130,307	0	0	0	3,967,241	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	-130,307	0	0	0	3,967,241	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/31/2019 10:59 am

	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
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-26,990	CAP REL COSTS-BLDG & FIXT	1.00	9	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)	B	-500,926	ADMINISTRATIVE & GENERAL	5.00	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	-638,934			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	594,599			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-275,654	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,773	ADMINISTRATIVE & GENERAL	5.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-7,232	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PROPERTY TAXES (51009800)	A	148,652	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/31/2019 10:59 am

	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	
33.01	ADVERTISING (41860XXX)	A	-200	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	RENTAL INCOME	B	-272,076	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS - OTHER OPERATING	B	-546	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	DISCOUNTS/REBATES	B	-703	CARDIAC CATHETERIZATION	59.00	0	33.04
33.05	HAF ASSESSMENT FEES	B	-971,786	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PENSION	A	42,696	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	MEDICAL STAFF FEES	B	-25,100	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	INTEREST INCOME - OTHER	B	20	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MISCELLANEOUS REVENUE	B	-3,116	RADIOLOGY-DIAGNOSTIC	54.00	0	33.09
33.10	LOBBYING	A	-1,261	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PROPERTY TAXES (51009800)	A	-2,072	RADIOLOGY-DIAGNOSTIC	54.00	0	33.11
33.12	PROPERTY TAXES (51009800)	A	-5,675	CT SCAN	57.00	0	33.12
33.13	PROPERTY TAXES (51009800)	A	-12,584	MRI	58.00	0	33.13
33.14	MISC OTHER OPERATING	B	-20	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	REFUNDS & REBATES	B	-176	CARDIAC CATHETERIZATION	59.00	0	33.15
33.16	REFUNDS & REBATES	B	-24,953	DIETARY	10.00	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,986,810				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: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2019 10:59 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	1,170,789	229,884	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAPITAL COSTS	1,513,101	5,121,983	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	A&G	9,931,978	7,583,969	3.00
4.00	15.00	PHARMACY	COVP / PHARMACY	154,091	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	HIM	760,476	0	4.01
4.02	0.00			0	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			13,530,435	12,935,836	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0165	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/31/2019 10:59 am

	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	940,905	11		1.00
2.00	-3,608,882	9		2.00
3.00	2,348,009	0		3.00
4.00	154,091	0		4.00
4.01	760,476	0		4.01
4.02	0	0		4.02
5.00	594,599			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: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2019 10:59 am

	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	900	900	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	5,650	5,650	0	0	0	2.00
3.00	50.00	OPERATING ROOM	591,163	591,163	0	0	0	3.00
4.00	50.00	OPERATING ROOM	4,250	0	4,250	200,300	34	4.00
5.00	50.00	OPERATING ROOM	36,000	0	36,000	200,300	240	5.00
6.00	59.00	CARDIAC CATHETERIZATION	3	3	0	0	0	6.00
7.00	60.00	LABORATORY	24,090	0	18,270	200,300	135	7.00
8.00	70.00	ELECTROENCEPHALOGRAPHY	30,000	0	30,000	200,300	240	8.00
9.00	76.01	CARDIAC AND PULMONARY REHAB	938	938	0	0	0	9.00
10.00	90.02	CLINIC	8,438	8,438	0	0	0	10.00
200.00			701,432	607,092	88,520		649	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	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	3,274	164	0	0	0	4.00
5.00	50.00	OPERATING ROOM	23,112	1,156	0	0	0	5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	13,000	650	0	0	0	7.00
8.00	70.00	ELECTROENCEPHALOGRAPHY	23,112	1,156	0	0	0	8.00
9.00	76.01	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	9.00
10.00	90.02	CLINIC	0	0	0	0	0	10.00
200.00			62,498	3,126	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	900		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	5,650		2.00
3.00	50.00	OPERATING ROOM	0	0	0	591,163		3.00
4.00	50.00	OPERATING ROOM	0	3,274	976	976		4.00
5.00	50.00	OPERATING ROOM	0	23,112	12,888	12,888		5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	0	0	3		6.00
7.00	60.00	LABORATORY	0	13,000	5,270	11,090		7.00
8.00	70.00	ELECTROENCEPHALOGRAPHY	0	23,112	6,888	6,888		8.00
9.00	76.01	CARDIAC AND PULMONARY REHAB	0	0	0	938		9.00
10.00	90.02	CLINIC	0	0	0	8,438		10.00
200.00			0	62,498	26,022	638,934		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/31/2019 10:59 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,967,241	3,967,241				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,738,838	50,325	0	8,789,163		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,344,091	483,682	0	2,081,772	20,909,545	5.00
6.00	00600	MAINTENANCE & REPAIRS	3,020,526	0	0	139,131	3,159,657	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	93,238	0	0	0	93,238	8.00
9.00	00900	HOUSEKEEPING	824,483	0	0	150,471	974,954	9.00
10.00	01000	DIETARY	816,508	173,811	0	128,405	1,118,724	10.00
11.00	01100	CAFETERIA	-282,886	0	0	0	-282,886	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,422,797	0	0	311,516	1,734,313	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	436,757	0	0	64,755	501,512	14.00
15.00	01500	PHARMACY	1,732,339	67,512	0	248,179	2,048,030	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,026,601	3,177	0	64,645	1,094,423	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,730,750	846,923	0	1,564,091	9,141,764	30.00
31.00	03100	INTENSIVE CARE UNIT	1,409,403	204,081	0	350,524	1,964,008	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,984,371	384,378	0	903,792	6,272,541	50.00
51.00	05100	RECOVERY ROOM	1,221,119	168,626	0	306,677	1,696,422	51.00
53.00	05300	ANESTHESIOLOGY	161,756	0	0	7,710	169,466	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,123,804	178,709	0	440,571	2,743,084	54.00
57.00	05700	CT SCAN	982,891	0	0	129,469	1,112,360	57.00
58.00	05800	MRI	1,440,728	0	0	182,729	1,623,457	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,102,140	363,043	0	216,654	1,681,837	59.00
60.00	06000	LABORATORY	3,501,519	62,394	0	0	3,563,913	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	26,630	0	0	26,630	64.01
65.00	06500	RESPIRATORY THERAPY	734,687	31,086	0	171,892	937,665	65.00
66.00	06600	PHYSICAL THERAPY	307,661	0	0	77,537	385,198	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,925	0	0	25,183	125,108	67.00
68.00	06800	SPEECH PATHOLOGY	39,087	0	0	9,721	48,808	68.00
69.00	06900	ELECTROCARDIOLOGY	315,936	0	0	71,923	387,859	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,210,708	158,653	0	109,293	1,478,654	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,642,316	0	0	0	3,642,316	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,387,713	0	0	0	7,387,713	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,566,632	0	0	0	2,566,632	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	193,092	0	0	47,022	240,114	76.01
76.02	03952	WOUND CARE	79,904	0	0	20,091	99,995	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	624,750	0	0	146,707	771,457	90.01
90.02	09002	CLINIC	619,187	26,630	0	99,598	745,415	90.02
91.00	09100	EMERGENCY	2,027,987	218,422	0	377,366	2,623,775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,648,599	3,448,082	0	8,447,424	82,787,701	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	80,549	0	0	13,450	93,999	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,638,861	519,159	0	325,779	2,483,799	192.00
192.01	19201	CENTER OF HOPE	9,902	0	0	2,510	12,412	192.01
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)	85,377,911	3,967,241	0	8,789,163	85,377,911	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/31/2019 10:59 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,909,545					5.00
6.00	00600	MAINTENANCE & REPAIRS	1,020,320	4,179,977				6.00
7.00	00700	OPERATION OF PLANT	0	0	0			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,109	0	0	123,347		8.00
9.00	00900	HOUSEKEEPING	314,833	0	0	308	1,290,095	9.00
10.00	01000	DIETARY	361,259	211,615	0	0	65,312	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	560,046	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	161,949	0	0	0	0	14.00
15.00	01500	PHARMACY	661,352	82,196	0	0	25,369	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	353,412	3,868	0	0	1,194	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,952,077	1,031,134	0	105,867	318,244	30.00
31.00	03100	INTENSIVE CARE UNIT	634,219	248,469	0	17,172	76,687	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,025,535	467,982	0	0	144,436	50.00
51.00	05100	RECOVERY ROOM	547,810	205,303	0	0	63,364	51.00
53.00	05300	ANESTHESIOLOGY	54,724	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	885,799	217,578	0	0	67,153	54.00
57.00	05700	CT SCAN	359,204	0	0	0	0	57.00
58.00	05800	MRI	524,248	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	543,100	442,007	0	0	136,420	59.00
60.00	06000	LABORATORY	1,150,862	75,964	0	0	23,445	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	8,599	32,422	0	0	10,007	64.01
65.00	06500	RESPIRATORY THERAPY	302,792	37,848	0	0	11,681	65.00
66.00	06600	PHYSICAL THERAPY	124,389	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,400	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,761	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	125,248	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	477,488	193,161	0	0	59,617	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,176,180	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,385,648	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	828,819	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	77,538	0	0	0	0	76.01
76.02	03952	WOUND CARE	32,290	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	249,120	0	0	0	0	90.01
90.02	09002	CLINIC	240,710	32,422	0	0	10,007	90.02
91.00	09100	EMERGENCY	847,272	265,929	0	0	82,076	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,073,112	3,547,898	0	123,347	1,095,012	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	30,354	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	802,071	632,079	0	0	195,083	192.00
192.01	19201	CENTER OF HOPE	4,008	0	0	0	0	192.01
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)	20,909,545	4,179,977	0	123,347	1,290,095	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/31/2019 10:59 am

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,756,910					10.00
11.00	01100	CAFETERIA	0	-282,886				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,294,359		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	663,461	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	35,835	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,511,715	0	0	873,141	0	30.00
31.00	03100	INTENSIVE CARE UNIT	245,195	0	0	273,766	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	332,339	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	242,842	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	910	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	4,184	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	94,226	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	127,333	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	663,461	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	14,552	0	90.01
90.02	09002	CLINIC	0	0	0	45,840	0	90.02
91.00	09100	EMERGENCY	0	0	0	249,391	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,756,910	0	0	2,294,359	663,461	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	CENTER OF HOPE	0	0	0	0	0	192.01
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	-282,886	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,756,910	-282,886	0	2,294,359	663,461	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/31/2019 10:59 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,816,947					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,488,732				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	106,056	16,039,998	0	16,039,998	30.00
31.00	03100	INTENSIVE CARE UNIT	0	20,570	3,480,086	0	3,480,086	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	205,429	9,448,262	0	9,448,262	50.00
51.00	05100	RECOVERY ROOM	0	28,116	2,783,857	0	2,783,857	51.00
53.00	05300	ANESTHESIOLOGY	0	61,064	285,254	0	285,254	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	122,476	4,037,000	0	4,037,000	54.00
57.00	05700	CT SCAN	0	137,370	1,608,934	0	1,608,934	57.00
58.00	05800	MRI	0	86,136	2,238,025	0	2,238,025	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	69,395	2,966,985	0	2,966,985	59.00
60.00	06000	LABORATORY	0	126,605	4,940,789	0	4,940,789	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	77,658	0	77,658	64.01
65.00	06500	RESPIRATORY THERAPY	0	37,286	1,327,272	0	1,327,272	65.00
66.00	06600	PHYSICAL THERAPY	0	7,560	517,147	0	517,147	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,146	168,654	0	168,654	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,303	65,872	0	65,872	68.00
69.00	06900	ELECTROCARDIOLOGY	0	39,030	679,470	0	679,470	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	24,231	2,233,151	0	2,233,151	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	45,814	5,527,771	0	5,527,771	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	73,637	9,846,998	0	9,846,998	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,816,947	91,575	6,303,973	0	6,303,973	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	1,548	319,200	0	319,200	76.01
76.02	03952	WOUND CARE	0	1,905	134,190	0	134,190	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	42,694	1,077,823	0	1,077,823	90.01
90.02	09002	CLINIC	0	37,614	1,112,008	0	1,112,008	90.02
91.00	09100	EMERGENCY	0	118,172	4,186,615	0	4,186,615	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,816,947	1,488,732	81,406,992	0	81,406,992	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	124,353	0	124,353	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,113,032	0	4,113,032	192.00
192.01	19201	CENTER OF HOPE	0	0	16,420	0	16,420	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	-282,886	0	-282,886	201.00
202.00		TOTAL (sum lines 118 through 201)	2,816,947	1,488,732	85,377,911	0	85,377,911	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/31/2019 10:59 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	50,325	0	50,325	50,325	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	483,682	0	483,682	11,928	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	796	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	861	9.00
10.00	01000	DIETARY	0	173,811	0	173,811	735	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	1,783	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	371	14.00
15.00	01500	PHARMACY	0	67,512	0	67,512	1,421	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,177	0	3,177	370	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	846,923	0	846,923	8,954	30.00
31.00	03100	INTENSIVE CARE UNIT	0	204,081	0	204,081	2,007	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	384,378	0	384,378	5,174	50.00
51.00	05100	RECOVERY ROOM	0	168,626	0	168,626	1,756	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	44	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	178,709	0	178,709	2,522	54.00
57.00	05700	CT SCAN	0	0	0	0	741	57.00
58.00	05800	MRI	0	0	0	0	1,046	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	363,043	0	363,043	1,240	59.00
60.00	06000	LABORATORY	0	62,394	0	62,394	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	26,630	0	26,630	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	31,086	0	31,086	984	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	444	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	144	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	56	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	412	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	158,653	0	158,653	626	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	269	76.01
76.02	03952	WOUND CARE	0	0	0	0	115	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	840	90.01
90.02	09002	CLINIC	0	26,630	0	26,630	570	90.02
91.00	09100	EMERGENCY	0	218,422	0	218,422	2,160	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,448,082	0	3,448,082	48,369	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	77	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	519,159	0	519,159	1,865	192.00
192.01	19201	CENTER OF HOPE	0	0	0	0	14	192.01
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)	0	3,967,241	0	3,967,241	50,325	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/31/2019 10:59 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	495,610					5.00
6.00	00600	MAINTENANCE & REPAIRS	24,184	24,980				6.00
7.00	00700	OPERATION OF PLANT	0	0	0			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	714	0	0	714		8.00
9.00	00900	HOUSEKEEPING	7,462	0	0	2	8,325	9.00
10.00	01000	DIETARY	8,563	1,265	0	0	421	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	13,274	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,839	0	0	0	0	14.00
15.00	01500	PHARMACY	15,676	491	0	0	164	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,377	23	0	0	8	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,973	6,163	0	613	2,053	30.00
31.00	03100	INTENSIVE CARE UNIT	15,033	1,485	0	99	495	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	48,010	2,797	0	0	932	50.00
51.00	05100	RECOVERY ROOM	12,984	1,227	0	0	409	51.00
53.00	05300	ANESTHESIOLOGY	1,297	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,996	1,300	0	0	433	54.00
57.00	05700	CT SCAN	8,514	0	0	0	0	57.00
58.00	05800	MRI	12,426	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,873	2,641	0	0	880	59.00
60.00	06000	LABORATORY	27,278	454	0	0	151	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	204	194	0	0	65	64.01
65.00	06500	RESPIRATORY THERAPY	7,177	226	0	0	75	65.00
66.00	06600	PHYSICAL THERAPY	2,948	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	958	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	374	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,969	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,318	1,154	0	0	385	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,878	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	56,546	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,645	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	1,838	0	0	0	0	76.01
76.02	03952	WOUND CARE	765	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	5,905	0	0	0	0	90.01
90.02	09002	CLINIC	5,705	194	0	0	65	90.02
91.00	09100	EMERGENCY	20,082	1,589	0	0	530	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	475,785	21,203	0	714	7,066	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	719	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,011	3,777	0	0	1,259	192.00
192.01	19201	CENTER OF HOPE	95	0	0	0	0	192.01
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)	495,610	24,980	0	714	8,325	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/31/2019 10:59 am

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	184,795					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	15,057		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	4,210	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	235	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	159,005	0	0	5,729	0	30.00
31.00	03100	INTENSIVE CARE UNIT	25,790	0	0	1,797	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,181	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,594	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	27	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	618	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	836	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,210	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	96	0	90.01
90.02	09002	CLINIC	0	0	0	301	0	90.02
91.00	09100	EMERGENCY	0	0	0	1,637	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	184,795	0	0	15,057	4,210	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	CENTER OF HOPE	0	0	0	0	0	192.01
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)	184,795	0	0	15,057	4,210	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/31/2019 10:59 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	85,264					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,190				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	872	1,100,285	0	1,100,285	30.00
31.00	03100	INTENSIVE CARE UNIT	0	169	250,956	0	250,956	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,640	445,112	0	445,112	50.00
51.00	05100	RECOVERY ROOM	0	231	186,827	0	186,827	51.00
53.00	05300	ANESTHESIOLOGY	0	502	1,843	0	1,843	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,007	204,973	0	204,973	54.00
57.00	05700	CT SCAN	0	1,129	10,384	0	10,384	57.00
58.00	05800	MRI	0	708	14,207	0	14,207	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	570	381,865	0	381,865	59.00
60.00	06000	LABORATORY	0	1,041	91,318	0	91,318	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	27,093	0	27,093	64.01
65.00	06500	RESPIRATORY THERAPY	0	307	39,855	0	39,855	65.00
66.00	06600	PHYSICAL THERAPY	0	62	3,454	0	3,454	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	26	1,128	0	1,128	67.00
68.00	06800	SPEECH PATHOLOGY	0	11	441	0	441	68.00
69.00	06900	ELECTROCARDIOLOGY	0	321	4,538	0	4,538	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	199	172,335	0	172,335	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	377	32,465	0	32,465	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	605	57,151	0	57,151	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,264	753	105,662	0	105,662	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	13	2,120	0	2,120	76.01
76.02	03952	WOUND CARE	0	16	896	0	896	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	351	7,192	0	7,192	90.01
90.02	09002	CLINIC	0	309	33,774	0	33,774	90.02
91.00	09100	EMERGENCY	0	971	245,391	0	245,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,264	12,190	3,421,265	0	3,421,265	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	796	0	796	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	545,071	0	545,071	192.00
192.01	19201	CENTER OF HOPE	0	0	109	0	109	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	85,264	12,190	3,967,241	0	3,967,241	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/31/2019 10:59 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	179,816					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		179,816				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,281	2,281	34,675,736			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,923	21,923	8,213,163	-20,909,545	64,751,252	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	548,912	0	3,159,657	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	93,238	8.00
9.00	00900	HOUSEKEEPING	0	0	593,651	0	974,954	9.00
10.00	01000	DIETARY	7,878	7,878	506,595	0	1,118,724	10.00
11.00	01100	CAFETERIA	0	0	0	282,886	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,229,021	0	1,734,313	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	255,479	0	501,512	14.00
15.00	01500	PHARMACY	3,060	3,060	979,137	0	2,048,030	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	144	144	255,043	0	1,094,423	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,387	38,387	6,170,786	0	9,141,764	30.00
31.00	03100	INTENSIVE CARE UNIT	9,250	9,250	1,382,916	0	1,964,008	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,422	17,422	3,565,718	0	6,272,541	50.00
51.00	05100	RECOVERY ROOM	7,643	7,643	1,209,929	0	1,696,422	51.00
53.00	05300	ANESTHESIOLOGY	0	0	30,417	0	169,466	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,100	8,100	1,738,180	0	2,743,084	54.00
57.00	05700	CT SCAN	0	0	510,791	0	1,112,360	57.00
58.00	05800	MRI	0	0	720,917	0	1,623,457	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,455	16,455	854,761	0	1,681,837	59.00
60.00	06000	LABORATORY	2,828	2,828	0	0	3,563,913	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	1,207	1,207	0	0	26,630	64.01
65.00	06500	RESPIRATORY THERAPY	1,409	1,409	678,162	0	937,665	65.00
66.00	06600	PHYSICAL THERAPY	0	0	305,906	0	385,198	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	99,354	0	125,108	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	38,351	0	48,808	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	283,756	0	387,859	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,191	7,191	431,194	0	1,478,654	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,642,316	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7,387,713	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,566,632	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	185,516	0	240,114	76.01
76.02	03952	WOUND CARE	0	0	79,264	0	99,995	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	578,802	0	771,457	90.01
90.02	09002	CLINIC	1,207	1,207	392,942	0	745,415	90.02
91.00	09100	EMERGENCY	9,900	9,900	1,488,817	0	2,623,775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	156,285	156,285	33,327,480	-20,626,659	62,161,042	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	53,063	0	93,999	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,531	23,531	1,285,291	0	2,483,799	192.00
192.01	19201	CENTER OF HOPE	0	0	9,902	0	12,412	192.01
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)	3,967,241	0	8,789,163		20,909,545	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.062781	0.000000	0.253467		0.322921	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			50,325		495,610	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001451		0.007654	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: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/31/2019 10:59 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	155,612					6.00
7.00	00700	OPERATION OF PLANT	0	155,612				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	339,855			8.00
9.00	00900	HOUSEKEEPING	0	0	848	155,612		9.00
10.00	01000	DIETARY	7,878	7,878	0	7,878	65,169	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,060	3,060	0	3,060	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	144	144	0	144	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,387	38,387	291,693	38,387	56,074	30.00
31.00	03100	INTENSIVE CARE UNIT	9,250	9,250	47,314	9,250	9,095	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,422	17,422	0	17,422	0	50.00
51.00	05100	RECOVERY ROOM	7,643	7,643	0	7,643	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,100	8,100	0	8,100	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,455	16,455	0	16,455	0	59.00
60.00	06000	LABORATORY	2,828	2,828	0	2,828	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	1,207	1,207	0	1,207	0	64.01
65.00	06500	RESPIRATORY THERAPY	1,409	1,409	0	1,409	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,191	7,191	0	7,191	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	1,207	1,207	0	1,207	0	90.02
91.00	09100	EMERGENCY	9,900	9,900	0	9,900	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	132,081	132,081	339,855	132,081	65,169	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,531	23,531	0	23,531	0	192.00
192.01	19201	CENTER OF HOPE	0	0	0	0	0	192.01
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)	4,179,977	0	123,347	1,290,095	1,756,910	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.861534	0.000000	0.362940	8.290460	26.959290	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,980	0	714	8,325	184,795	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.160527	0.000000	0.002101	0.053498	2.835627	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: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/31/2019 10:59 am

		Cost Center Description	CAFETERIA (NUMBER HOUSED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	0	12,613			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	100		14.00
15.00	01500	PHARMACY	0	0	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	197	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,800	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	1,505	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	1,827	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	1,335	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	23	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	518	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	700	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	100	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	100	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	80	0	0	90.01
90.02	09002	CLINIC	0	0	252	0	0	90.02
91.00	09100	EMERGENCY	0	0	1,371	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	12,613	100	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	CENTER OF HOPE	0	0	0	0	0	192.01
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)	-282,886	0	2,294,359	663,461	2,816,947	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	181.904305	6,634.610000	28,169.470000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	15,057	4,210	85,264	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	1.193768	42.100000	852.640000	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: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/31/2019 10:59 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)				
			16.00				
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
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	359,961,085				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	25,642,095				30.00
31.00	03100	INTENSIVE CARE UNIT	4,973,509				31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	49,684,925				50.00
51.00	05100	RECOVERY ROOM	6,797,863				51.00
53.00	05300	ANESTHESIOLOGY	14,763,967				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,612,116				54.00
57.00	05700	CT SCAN	33,213,228				57.00
58.00	05800	MRI	20,825,919				58.00
59.00	05900	CARDIAC CATHETERIZATION	16,778,276				59.00
60.00	06000	LABORATORY	30,610,383				60.00
64.00	06400	INTRAVENOUS THERAPY	0				64.00
64.01	06401	INTRAVENOUS THERAPY	0				64.01
65.00	06500	RESPIRATORY THERAPY	9,015,027				65.00
66.00	06600	PHYSICAL THERAPY	1,827,909				66.00
67.00	06700	OCCUPATIONAL THERAPY	760,636				67.00
68.00	06800	SPEECH PATHOLOGY	315,015				68.00
69.00	06900	ELECTROCARDIOLOGY	9,436,579				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,858,599				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,076,973				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,803,822				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,140,886				73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0				76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	374,343				76.01
76.02	03952	WOUND CARE	460,605				76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0				90.00
90.01	09001	CLINIC	10,322,592				90.01
90.02	09002	CLINIC	9,094,292				90.02
91.00	09100	EMERGENCY	28,571,526				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	359,961,085				118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0				190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0				192.00
192.01	19201	CENTER OF HOPE	0				192.01
193.00	19300	NONPAID WORKERS	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)	1,488,732				202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004136				203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,190				204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000034				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: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/31/2019 10:59 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,039,998		16,039,998	0	16,039,998	30.00
31.00	03100	INTENSIVE CARE UNIT	3,480,086		3,480,086	0	3,480,086	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,448,262		9,448,262	13,864	9,462,126	50.00
51.00	05100	RECOVERY ROOM	2,783,857		2,783,857	0	2,783,857	51.00
53.00	05300	ANESTHESIOLOGY	285,254		285,254	0	285,254	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,037,000		4,037,000	0	4,037,000	54.00
57.00	05700	CT SCAN	1,608,934		1,608,934	0	1,608,934	57.00
58.00	05800	MRI	2,238,025		2,238,025	0	2,238,025	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,966,985		2,966,985	0	2,966,985	59.00
60.00	06000	LABORATORY	4,940,789		4,940,789	5,270	4,946,059	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	77,658		77,658	0	77,658	64.01
65.00	06500	RESPIRATORY THERAPY	1,327,272	0	1,327,272	0	1,327,272	65.00
66.00	06600	PHYSICAL THERAPY	517,147	0	517,147	0	517,147	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,654	0	168,654	0	168,654	67.00
68.00	06800	SPEECH PATHOLOGY	65,872	0	65,872	0	65,872	68.00
69.00	06900	ELECTROCARDIOLOGY	679,470		679,470	0	679,470	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,233,151		2,233,151	6,888	2,240,039	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,527,771		5,527,771	0	5,527,771	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,846,998		9,846,998	0	9,846,998	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,303,973		6,303,973	0	6,303,973	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	319,200		319,200	0	319,200	76.01
76.02	03952	WOUND CARE	134,190		134,190	0	134,190	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	CLINIC	1,077,823		1,077,823	0	1,077,823	90.01
90.02	09002	CLINIC	1,112,008		1,112,008	0	1,112,008	90.02
91.00	09100	EMERGENCY	4,186,615		4,186,615	0	4,186,615	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	81,406,992	0	81,406,992	26,022	81,433,014	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	81,406,992	0	81,406,992	26,022	81,433,014	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/31/2019 10:59 am

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		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	19,803,598		19,803,598			30.00
31.00	03100	INTENSIVE CARE UNIT	4,973,509		4,973,509			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,101,864	39,583,061	49,684,925	0.190164	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,245,271	5,552,592	6,797,863	0.409519	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	3,267,536	11,496,431	14,763,967	0.019321	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,440,690	26,171,426	29,612,116	0.136329	0.000000	54.00
57.00	05700	CT SCAN	5,725,258	27,487,970	33,213,228	0.048443	0.000000	57.00
58.00	05800	MRI	1,731,324	19,094,595	20,825,919	0.107463	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,399,186	7,379,090	16,778,276	0.176835	0.000000	59.00
60.00	06000	LABORATORY	11,807,744	18,802,639	30,610,383	0.161409	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	5,454,361	3,560,666	9,015,027	0.147229	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,451,778	376,131	1,827,909	0.282917	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	657,946	102,690	760,636	0.221728	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	292,001	23,014	315,015	0.209108	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,755,226	6,681,353	9,436,579	0.072004	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,858,599	5,858,599	0.381175	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,606,872	6,470,101	11,076,973	0.499033	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,815,285	7,988,537	17,803,822	0.553083	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,969,220	9,171,666	22,140,886	0.284721	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	374,343	374,343	0.852694	0.000000	76.01
76.02	03952	WOUND CARE	3,764	456,841	460,605	0.291334	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CLINIC	239,103	10,083,489	10,322,592	0.104414	0.000000	90.01
90.02	09002	CLINIC	4,192,783	4,901,509	9,094,292	0.122275	0.000000	90.02
91.00	09100	EMERGENCY	7,131,073	21,440,453	28,571,526	0.146531	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,888,757	3,949,740	5,838,497	0.000000	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	122,954,149	237,006,936	359,961,085			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	122,954,149	237,006,936	359,961,085			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/31/2019 10:59 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.190443	50.00
51.00	05100	RECOVERY ROOM	0.409519	51.00
53.00	05300	ANESTHESIOLOGY	0.019321	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136329	54.00
57.00	05700	CT SCAN	0.048443	57.00
58.00	05800	MRI	0.107463	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176835	59.00
60.00	06000	LABORATORY	0.161581	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	0.147229	65.00
66.00	06600	PHYSICAL THERAPY	0.282917	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.221728	67.00
68.00	06800	SPEECH PATHOLOGY	0.209108	68.00
69.00	06900	ELECTROCARDIOLOGY	0.072004	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.382351	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.499033	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.553083	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284721	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.852694	76.01
76.02	03952	WOUND CARE	0.291334	76.02
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	CLINIC	0.104414	90.01
90.02	09002	CLINIC	0.122275	90.02
91.00	09100	EMERGENCY	0.146531	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/31/2019 10:59 am

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		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	16,039,998		16,039,998	0	16,039,998	30.00
31.00	03100	INTENSIVE CARE UNIT	3,480,086		3,480,086	0	3,480,086	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,448,262		9,448,262	13,864	9,462,126	50.00
51.00	05100	RECOVERY ROOM	2,783,857		2,783,857	0	2,783,857	51.00
53.00	05300	ANESTHESIOLOGY	285,254		285,254	0	285,254	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,037,000		4,037,000	0	4,037,000	54.00
57.00	05700	CT SCAN	1,608,934		1,608,934	0	1,608,934	57.00
58.00	05800	MRI	2,238,025		2,238,025	0	2,238,025	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,966,985		2,966,985	0	2,966,985	59.00
60.00	06000	LABORATORY	4,940,789		4,940,789	5,270	4,946,059	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	77,658		77,658	0	77,658	64.01
65.00	06500	RESPIRATORY THERAPY	1,327,272	0	1,327,272	0	1,327,272	65.00
66.00	06600	PHYSICAL THERAPY	517,147	0	517,147	0	517,147	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,654	0	168,654	0	168,654	67.00
68.00	06800	SPEECH PATHOLOGY	65,872	0	65,872	0	65,872	68.00
69.00	06900	ELECTROCARDIOLOGY	679,470		679,470	0	679,470	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,233,151		2,233,151	6,888	2,240,039	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,527,771		5,527,771	0	5,527,771	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,846,998		9,846,998	0	9,846,998	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,303,973		6,303,973	0	6,303,973	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	319,200		319,200	0	319,200	76.01
76.02	03952	WOUND CARE	134,190		134,190	0	134,190	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	CLINIC	1,077,823		1,077,823	0	1,077,823	90.01
90.02	09002	CLINIC	1,112,008		1,112,008	0	1,112,008	90.02
91.00	09100	EMERGENCY	4,186,615		4,186,615	0	4,186,615	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	81,406,992	0	81,406,992	26,022	81,433,014	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	81,406,992	0	81,406,992	26,022	81,433,014	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/31/2019 10:59 am

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		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	19,803,598		19,803,598			30.00
31.00	03100	INTENSIVE CARE UNIT	4,973,509		4,973,509			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,101,864	39,583,061	49,684,925	0.190164	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,245,271	5,552,592	6,797,863	0.409519	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	3,267,536	11,496,431	14,763,967	0.019321	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,440,690	26,171,426	29,612,116	0.136329	0.000000	54.00
57.00	05700	CT SCAN	5,725,258	27,487,970	33,213,228	0.048443	0.000000	57.00
58.00	05800	MRI	1,731,324	19,094,595	20,825,919	0.107463	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,399,186	7,379,090	16,778,276	0.176835	0.000000	59.00
60.00	06000	LABORATORY	11,807,744	18,802,639	30,610,383	0.161409	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	5,454,361	3,560,666	9,015,027	0.147229	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,451,778	376,131	1,827,909	0.282917	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	657,946	102,690	760,636	0.221728	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	292,001	23,014	315,015	0.209108	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,755,226	6,681,353	9,436,579	0.072004	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,858,599	5,858,599	0.381175	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,606,872	6,470,101	11,076,973	0.499033	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,815,285	7,988,537	17,803,822	0.553083	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,969,220	9,171,666	22,140,886	0.284721	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	374,343	374,343	0.852694	0.000000	76.01
76.02	03952	WOUND CARE	3,764	456,841	460,605	0.291334	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CLINIC	239,103	10,083,489	10,322,592	0.104414	0.000000	90.01
90.02	09002	CLINIC	4,192,783	4,901,509	9,094,292	0.122275	0.000000	90.02
91.00	09100	EMERGENCY	7,131,073	21,440,453	28,571,526	0.146531	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,888,757	3,949,740	5,838,497	0.000000	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	122,954,149	237,006,936	359,961,085			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	122,954,149	237,006,936	359,961,085			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/31/2019 10:59 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.190443	50.00
51.00	05100	RECOVERY ROOM	0.409519	51.00
53.00	05300	ANESTHESIOLOGY	0.019321	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136329	54.00
57.00	05700	CT SCAN	0.048443	57.00
58.00	05800	MRI	0.107463	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176835	59.00
60.00	06000	LABORATORY	0.161581	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	0.147229	65.00
66.00	06600	PHYSICAL THERAPY	0.282917	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.221728	67.00
68.00	06800	SPEECH PATHOLOGY	0.209108	68.00
69.00	06900	ELECTROCARDIOLOGY	0.072004	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.382351	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.499033	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.553083	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284721	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.852694	76.01
76.02	03952	WOUND CARE	0.291334	76.02
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	CLINIC	0.104414	90.01
90.02	09002	CLINIC	0.122275	90.02
91.00	09100	EMERGENCY	0.146531	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part II Date/Time Prepared: 5/31/2019 10:59 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,448,262	445,112	9,003,150	0	0	50.00
51.00	05100	RECOVERY ROOM	2,783,857	186,827	2,597,030	0	0	51.00
53.00	05300	ANESTHESIOLOGY	285,254	1,843	283,411	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,037,000	204,973	3,832,027	0	0	54.00
57.00	05700	CT SCAN	1,608,934	10,384	1,598,550	0	0	57.00
58.00	05800	MRI	2,238,025	14,207	2,223,818	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,966,985	381,865	2,585,120	0	0	59.00
60.00	06000	LABORATORY	4,940,789	91,318	4,849,471	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	77,658	27,093	50,565	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	1,327,272	39,855	1,287,417	0	0	65.00
66.00	06600	PHYSICAL THERAPY	517,147	3,454	513,693	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,654	1,128	167,526	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	65,872	441	65,431	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	679,470	4,538	674,932	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,233,151	172,335	2,060,816	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,527,771	32,465	5,495,306	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,846,998	57,151	9,789,847	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,303,973	105,662	6,198,311	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	319,200	2,120	317,080	0	0	76.01
76.02	03952	WOUND CARE	134,190	896	133,294	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	1,077,823	7,192	1,070,631	0	0	90.01
90.02	09002	CLINIC	1,112,008	33,774	1,078,234	0	0	90.02
91.00	09100	EMERGENCY	4,186,615	245,391	3,941,224	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	61,886,908	2,070,024	59,816,884	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	61,886,908	2,070,024	59,816,884	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part II Date/Time Prepared: 5/31/2019 10:59 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	9,448,262	49,684,925	0.190164		50.00
51.00	05100	RECOVERY ROOM	2,783,857	6,797,863	0.409519		51.00
53.00	05300	ANESTHESIOLOGY	285,254	14,763,967	0.019321		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,037,000	29,612,116	0.136329		54.00
57.00	05700	CT SCAN	1,608,934	33,213,228	0.048443		57.00
58.00	05800	MRI	2,238,025	20,825,919	0.107463		58.00
59.00	05900	CARDIAC CATHETERIZATION	2,966,985	16,778,276	0.176835		59.00
60.00	06000	LABORATORY	4,940,789	30,610,383	0.161409		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000		64.00
64.01	06401	INTRAVENOUS THERAPY	77,658	0	0.000000		64.01
65.00	06500	RESPIRATORY THERAPY	1,327,272	9,015,027	0.147229		65.00
66.00	06600	PHYSICAL THERAPY	517,147	1,827,909	0.282917		66.00
67.00	06700	OCCUPATIONAL THERAPY	168,654	760,636	0.221728		67.00
68.00	06800	SPEECH PATHOLOGY	65,872	315,015	0.209108		68.00
69.00	06900	ELECTROCARDIOLOGY	679,470	9,436,579	0.072004		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,233,151	5,858,599	0.381175		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,527,771	11,076,973	0.499033		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,846,998	17,803,822	0.553083		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,303,973	22,140,886	0.284721		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	319,200	374,343	0.852694		76.01
76.02	03952	WOUND CARE	134,190	460,605	0.291334		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
90.01	09001	CLINIC	1,077,823	10,322,592	0.104414		90.01
90.02	09002	CLINIC	1,112,008	9,094,292	0.122275		90.02
91.00	09100	EMERGENCY	4,186,615	28,571,526	0.146531		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,838,497	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	61,886,908	335,183,978			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	61,886,908	335,183,978			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/31/2019 10:59 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,100,285	0	1,100,285	9,858	111.61	30.00
31.00	INTENSIVE CARE UNIT	250,956		250,956	1,599	156.95	31.00
200.00	Total (lines 30 through 199)	1,351,241		1,351,241	11,457		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,641	517,982				30.00
31.00	INTENSIVE CARE UNIT	575	90,246				31.00
200.00	Total (lines 30 through 199)	5,216	608,228				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/31/2019 10:59 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	445,112	49,684,925	0.008959	667,770	5,983	50.00
51.00	05100	RECOVERY ROOM	186,827	6,797,863	0.027483	72,940	2,005	51.00
53.00	05300	ANESTHESIOLOGY	1,843	14,763,967	0.000125	1,141,998	143	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	204,973	29,612,116	0.006922	1,449,112	10,031	54.00
57.00	05700	CT SCAN	10,384	33,213,228	0.000313	2,663,065	834	57.00
58.00	05800	MRI	14,207	20,825,919	0.000682	1,402,237	956	58.00
59.00	05900	CARDIAC CATHETERIZATION	381,865	16,778,276	0.022759	2,670,100	60,769	59.00
60.00	06000	LABORATORY	91,318	30,610,383	0.002983	609,743	1,819	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	27,093	0	0.000000	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	39,855	9,015,027	0.004421	5,052,226	22,336	65.00
66.00	06600	PHYSICAL THERAPY	3,454	1,827,909	0.001890	694,259	1,312	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,128	760,636	0.001483	321,463	477	67.00
68.00	06800	SPEECH PATHOLOGY	441	315,015	0.001400	167,821	235	68.00
69.00	06900	ELECTROCARDIOLOGY	4,538	9,436,579	0.000481	438,031	211	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	172,335	5,858,599	0.029416	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,465	11,076,973	0.002931	1,853,794	5,433	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	57,151	17,803,822	0.003210	3,439,286	11,040	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	105,662	22,140,886	0.004772	6,120,875	29,209	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	2,120	374,343	0.005663	0	0	76.01
76.02	03952	WOUND CARE	896	460,605	0.001945	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	CLINIC	7,192	10,322,592	0.000697	52	0	90.01
90.02	09002	CLINIC	33,774	9,094,292	0.003714	4,192,783	15,572	90.02
91.00	09100	EMERGENCY	245,391	28,571,526	0.008589	3,000,907	25,775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,838,497	0.000000	891,253	0	92.00
200.00		Total (lines 50 through 199)	2,070,024	335,183,978		36,849,715	194,140	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/31/2019 10:59 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	9,858	0.00	4,641	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,599	0.00	575	31.00
200.00		Total (lines 30 through 199)		0	11,457		5,216	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/31/2019 10:59 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/31/2019 10:59 am

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		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	49,684,925	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,797,863	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	14,763,967	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,612,116	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	33,213,228	0.000000	57.00
58.00	05800	MRI	0	0	0	20,825,919	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	16,778,276	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	30,610,383	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,015,027	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,827,909	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	760,636	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	315,015	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	9,436,579	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,858,599	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,076,973	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,803,822	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,140,886	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	374,343	0.000000	76.01
76.02	03952	WOUND CARE	0	0	0	460,605	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	CLINIC	0	0	0	10,322,592	0.000000	90.01
90.02	09002	CLINIC	0	0	0	9,094,292	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	28,571,526	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,838,497	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	335,183,978		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/31/2019 10:59 am

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		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	667,770	0	5,216,480	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	72,940	0	712,614	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,141,998	0	2,556,339	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,449,112	0	4,376,010	0	54.00
57.00	05700	CT SCAN	0.000000	2,663,065	0	12,489,964	0	57.00
58.00	05800	MRI	0.000000	1,402,237	0	4,091,394	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,670,100	0	6,715,999	0	59.00
60.00	06000	LABORATORY	0.000000	609,743	0	1,177,074	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.000000	5,052,226	0	3,272,163	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	694,259	0	91,473	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	321,463	0	33,516	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	167,821	0	5,117	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	438,031	0	1,625,873	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	1,361	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,853,794	0	1,534,714	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,439,286	0	2,730,201	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,120,875	0	3,622,239	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.000000	0	0	370,542	0	76.01
76.02	03952	WOUND CARE	0.000000	0	0	118,981	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	0.000000	52	0	1,632,563	0	90.01
90.02	09002	CLINIC	0.000000	4,192,783	0	4,256,305	0	90.02
91.00	09100	EMERGENCY	0.000000	3,000,907	0	2,015,859	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	891,253	0	752,225	0	92.00
200.00		Total (lines 50 through 199)		36,849,715	0	59,399,006	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/31/2019 10:59 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.190164	5,216,480	0	0	991,987	50.00
51.00	05100	RECOVERY ROOM	0.409519	712,614	0	0	291,829	51.00
53.00	05300	ANESTHESIOLOGY	0.019321	2,556,339	0	0	49,391	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136329	4,376,010	0	0	596,577	54.00
57.00	05700	CT SCAN	0.048443	12,489,964	0	0	605,051	57.00
58.00	05800	MRI	0.107463	4,091,394	0	0	439,673	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176835	6,715,999	0	0	1,187,624	59.00
60.00	06000	LABORATORY	0.161409	1,177,074	0	0	189,990	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.147229	3,272,163	0	0	481,757	65.00
66.00	06600	PHYSICAL THERAPY	0.282917	91,473	0	0	25,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.221728	33,516	0	0	7,431	67.00
68.00	06800	SPEECH PATHOLOGY	0.209108	5,117	0	0	1,070	68.00
69.00	06900	ELECTROCARDIOLOGY	0.072004	1,625,873	0	0	117,069	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.381175	1,361	0	0	519	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.499033	1,534,714	0	0	765,873	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.553083	2,730,201	0	0	1,510,028	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284721	3,622,239	0	32,326	1,031,328	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.852694	370,542	0	0	315,959	76.01
76.02	03952	WOUND CARE	0.291334	118,981	0	0	34,663	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	0.104414	1,632,563	0	0	170,462	90.01
90.02	09002	CLINIC	0.122275	4,256,305	0	0	520,440	90.02
91.00	09100	EMERGENCY	0.146531	2,015,859	0	0	295,386	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	752,225	0	0	0	92.00
200.00		Subtotal (see instructions)		59,399,006	0	32,326	9,629,986	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		59,399,006	0	32,326	9,629,986	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/31/2019 10:59 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
64.01	06401	INTRAVENOUS THERAPY	0	0		64.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,204		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0		76.01
76.02	03952	WOUND CARE	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	9,204		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	9,204		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/31/2019 10:59 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,100,285	0	1,100,285	9,858	111.61	30.00
31.00	INTENSIVE CARE UNIT	250,956		250,956	1,599	156.95	31.00
200.00	Total (lines 30 through 199)	1,351,241		1,351,241	11,457		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	877	97,882				30.00
31.00	INTENSIVE CARE UNIT	170	26,682				31.00
200.00	Total (lines 30 through 199)	1,047	124,564				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/31/2019 10:59 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	445,112	49,684,925	0.008959	912,311	8,173	50.00
51.00	05100	RECOVERY ROOM	186,827	6,797,863	0.027483	112,216	3,084	51.00
53.00	05300	ANESTHESIOLOGY	1,843	14,763,967	0.000125	295,330	37	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	204,973	29,612,116	0.006922	305,698	2,116	54.00
57.00	05700	CT SCAN	10,384	33,213,228	0.000313	539,876	169	57.00
58.00	05800	MRI	14,207	20,825,919	0.000682	129,528	88	58.00
59.00	05900	CARDIAC CATHETERIZATION	381,865	16,778,276	0.022759	671,232	15,277	59.00
60.00	06000	LABORATORY	91,318	30,610,383	0.002983	1,148,083	3,425	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	27,093	0	0.000000	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	39,855	9,015,027	0.004421	402,135	1,778	65.00
66.00	06600	PHYSICAL THERAPY	3,454	1,827,909	0.001890	103,469	196	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,128	760,636	0.001483	39,755	59	67.00
68.00	06800	SPEECH PATHOLOGY	441	315,015	0.001400	5,236	7	68.00
69.00	06900	ELECTROCARDIOLOGY	4,538	9,436,579	0.000481	186,080	90	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	172,335	5,858,599	0.029416	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,465	11,076,973	0.002931	349,156	1,023	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	57,151	17,803,822	0.003210	679,133	2,180	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	105,662	22,140,886	0.004772	1,374,245	6,558	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	2,120	374,343	0.005663	0	0	76.01
76.02	03952	WOUND CARE	896	460,605	0.001945	334	1	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	CLINIC	7,192	10,322,592	0.000697	0	0	90.01
90.02	09002	CLINIC	33,774	9,094,292	0.003714	0	0	90.02
91.00	09100	EMERGENCY	245,391	28,571,526	0.008589	497,264	4,271	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,838,497	0.000000	154,340	0	92.00
200.00		Total (lines 50 through 199)	2,070,024	335,183,978		7,905,421	48,532	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/31/2019 10:59 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	9,858	0.00	877	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,599	0.00	170	31.00
200.00		Total (lines 30 through 199)		0	11,457		1,047	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/31/2019 10:59 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/31/2019 10:59 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	49,684,925	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,797,863	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	14,763,967	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,612,116	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	33,213,228	0.000000	57.00
58.00	05800	MRI	0	0	0	20,825,919	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	16,778,276	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	30,610,383	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,015,027	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,827,909	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	760,636	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	315,015	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	9,436,579	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,858,599	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,076,973	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,803,822	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,140,886	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	374,343	0.000000	76.01
76.02	03952	WOUND CARE	0	0	0	460,605	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	CLINIC	0	0	0	10,322,592	0.000000	90.01
90.02	09002	CLINIC	0	0	0	9,094,292	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	28,571,526	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,838,497	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	335,183,978		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/31/2019 10:59 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	912,311	0	5,338,868	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	112,216	0	847,069	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	295,330	0	1,662,598	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	305,698	0	3,138,586	0	54.00
57.00	05700	CT SCAN	0.000000	539,876	0	3,238,774	0	57.00
58.00	05800	MRI	0.000000	129,528	0	2,838,535	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	671,232	0	414,621	0	59.00
60.00	06000	LABORATORY	0.000000	1,148,083	0	2,922,767	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.000000	402,135	0	288,503	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	103,469	0	41,671	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	39,755	0	13,588	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	5,236	0	3,596	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	186,080	0	611,087	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	742,984	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	349,156	0	956,880	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	679,133	0	995,577	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,374,245	0	1,972,740	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.000000	0	0	3,801	0	76.01
76.02	03952	WOUND CARE	0.000000	334	0	35,125	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	1,298,888	0	90.01
90.02	09002	CLINIC	0.000000	0	0	645,204	0	90.02
91.00	09100	EMERGENCY	0.000000	497,264	0	4,638,369	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	154,340	0	758,028	0	92.00
200.00		Total (lines 50 through 199)		7,905,421	0	33,407,859	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/31/2019 10:59 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.190164	5,338,868	0	0	1,015,260	50.00
51.00	05100	RECOVERY ROOM	0.409519	847,069	0	0	346,891	51.00
53.00	05300	ANESTHESIOLOGY	0.019321	1,662,598	0	0	32,123	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136329	3,138,586	0	0	427,880	54.00
57.00	05700	CT SCAN	0.048443	3,238,774	0	0	156,896	57.00
58.00	05800	MRI	0.107463	2,838,535	0	0	305,037	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176835	414,621	0	0	73,320	59.00
60.00	06000	LABORATORY	0.161409	2,922,767	0	0	471,761	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.147229	288,503	0	0	42,476	65.00
66.00	06600	PHYSICAL THERAPY	0.282917	41,671	0	0	11,789	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.221728	13,588	0	0	3,013	67.00
68.00	06800	SPEECH PATHOLOGY	0.209108	3,596	0	0	752	68.00
69.00	06900	ELECTROCARDIOLOGY	0.072004	611,087	0	0	44,001	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.381175	742,984	0	0	283,207	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.499033	956,880	0	0	477,515	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.553083	995,577	0	0	550,637	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284721	1,972,740	0	0	561,681	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.852694	3,801	0	0	3,241	76.01
76.02	03952	WOUND CARE	0.291334	35,125	0	0	10,233	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	0.104414	1,298,888	0	0	135,622	90.01
90.02	09002	CLINIC	0.122275	645,204	0	0	78,892	90.02
91.00	09100	EMERGENCY	0.146531	4,638,369	0	0	679,665	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	758,028	0	0	0	92.00
200.00		Subtotal (see instructions)		33,407,859	0	0	5,711,892	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		33,407,859	0	0	5,711,892	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/31/2019 10:59 am

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
64.01	06401	INTRAVENOUS THERAPY	0	0		64.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0		76.01
76.02	03952	WOUND CARE	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/31/2019 10:59 am

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	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)	9,858	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,858	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)	9,858	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,641	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	16,039,998	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	16,039,998	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)	16,039,998	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,627.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,551,371	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)	7,551,371	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/31/2019 10:59 am

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	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	3,480,086	1,599	2,176.41	575	1,251,436	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)	7,827,672	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	16,630,479	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)	608,228	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	194,140	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	802,368	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	15,828,111	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/31/2019 10:59 am

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	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	1,100,285	16,039,998	0.068596	0	0	90.00
91.00	Nursing School cost	0	16,039,998	0.000000	0	0	91.00
92.00	Allied health cost	0	16,039,998	0.000000	0	0	92.00
93.00	All other Medical Education	0	16,039,998	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0165	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/31/2019 10:59 am
	Title XIX	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,858	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,858	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)	9,858	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	877	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	16,039,998	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	16,039,998	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)	16,039,998	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,627.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,426,967	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,426,967	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/31/2019 10:59 am

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	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	3,480,086	1,599	2,176.41	170	369,990	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,737,240	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,534,197	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)	124,564	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	48,532	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	173,096	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,361,101	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/31/2019 10:59 am

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	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	1,100,285	16,039,998	0.068596	0	0	90.00
91.00	Nursing School cost	0	16,039,998	0.000000	0	0	91.00
92.00	Allied health cost	0	16,039,998	0.000000	0	0	92.00
93.00	All other Medical Education	0	16,039,998	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/31/2019 10:59 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,154,465		30.00
31.00	03100	INTENSIVE CARE UNIT		3,976,514		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.190443	667,770	127,172	50.00
51.00	05100	RECOVERY ROOM	0.409519	72,940	29,870	51.00
53.00	05300	ANESTHESIOLOGY	0.019321	1,141,998	22,065	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136329	1,449,112	197,556	54.00
57.00	05700	CT SCAN	0.048443	2,663,065	129,007	57.00
58.00	05800	MRI	0.107463	1,402,237	150,689	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176835	2,670,100	472,167	59.00
60.00	06000	LABORATORY	0.161581	609,743	98,523	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.147229	5,052,226	743,834	65.00
66.00	06600	PHYSICAL THERAPY	0.282917	694,259	196,418	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.221728	321,463	71,277	67.00
68.00	06800	SPEECH PATHOLOGY	0.209108	167,821	35,093	68.00
69.00	06900	ELECTROCARDIOLOGY	0.072004	438,031	31,540	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.382351	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.499033	1,853,794	925,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.553083	3,439,286	1,902,211	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284721	6,120,875	1,742,742	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.852694	0	0	76.01
76.02	03952	WOUND CARE	0.291334	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC	0.104414	52	5	90.01
90.02	09002	CLINIC	0.122275	4,192,783	512,673	90.02
91.00	09100	EMERGENCY	0.146531	3,000,907	439,726	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	891,253	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		36,849,715	7,827,672	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)		36,849,715		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/31/2019 10:59 am

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		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		1,529,547		30.00
31.00	03100	INTENSIVE CARE UNIT		462,884		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.190443	912,311	173,743	50.00
51.00	05100	RECOVERY ROOM	0.409519	112,216	45,955	51.00
53.00	05300	ANESTHESIOLOGY	0.019321	295,330	5,706	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136329	305,698	41,676	54.00
57.00	05700	CT SCAN	0.048443	539,876	26,153	57.00
58.00	05800	MRI	0.107463	129,528	13,919	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176835	671,232	118,697	59.00
60.00	06000	LABORATORY	0.161581	1,148,083	185,508	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.147229	402,135	59,206	65.00
66.00	06600	PHYSICAL THERAPY	0.282917	103,469	29,273	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.221728	39,755	8,815	67.00
68.00	06800	SPEECH PATHOLOGY	0.209108	5,236	1,095	68.00
69.00	06900	ELECTROCARDIOLOGY	0.072004	186,080	13,399	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.382351	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.499033	349,156	174,240	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.553083	679,133	375,617	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284721	1,374,245	391,276	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.852694	0	0	76.01
76.02	03952	WOUND CARE	0.291334	334	97	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC	0.104414	0	0	90.01
90.02	09002	CLINIC	0.122275	0	0	90.02
91.00	09100	EMERGENCY	0.146531	497,264	72,865	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	154,340	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,905,421	1,737,240	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		7,905,421		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0165	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/31/2019 10:59 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	7,399,386	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,330,695	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	313,404	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	63.00	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.37	30.00
31.00	Percentage of Medicaid patient days (see instructions)	9.14	31.00
32.00	Sum of lines 30 and 31	12.51	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0165	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/31/2019 10:59 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000002039	0.000050907	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	11,043,485		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	11,043,485	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	923,990	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	11,967,475	59.00
60.00	Primary payer payments	32,432	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	11,935,043	61.00
62.00	Deductibles billed to program beneficiaries	1,034,264	62.00
63.00	Coinsurance billed to program beneficiaries	47,570	63.00
64.00	Allowable bad debts (see instructions)	124,594	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	80,986	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	43,846	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	10,934,195	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-67,992	70.93
70.94	HRR adjustment amount (see instructions)	-79,590	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0165	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/31/2019 10:59 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		36,726	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,749,887	71.00
71.01	Sequestration adjustment (see instructions)		214,998	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		10,455,512	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		79,377	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		64,810	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/31/2019 10:59 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,399,386	0	7,399,386		7,399,386	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,330,695	0		3,330,695	3,330,695	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	313,404	0	199,685	113,719	313,404	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,043,485	0	7,599,071	3,444,414	11,043,485	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,043,485	0	7,599,071	3,444,414	11,043,485	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	923,990	0	634,265	289,725	923,990	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/31/2019 10:59 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	8,233,336	3,734,139	11,967,475	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	873,743	0	602,750	270,993	873,743	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	50,247	0	31,515	18,732	50,247	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	923,990	0	634,265	289,725	923,990	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.138214	0.138214		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			1,137,962		1,137,962	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				516,110	516,110	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/31/2019 10:59 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,399,386	7,399,386		7,399,386	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,330,695		3,330,695	3,330,695	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	313,404	199,685	113,719	313,404	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,043,485	7,599,071	3,444,414	11,043,485	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,043,485	7,599,071	3,444,414	11,043,485	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	923,990	634,265	289,725	923,990	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			8,233,336	3,734,139	11,967,475	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/31/2019 10:59 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	873,743	602,750	270,993	873,743	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	50,247	31,515	18,732	50,247	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	923,990	634,265	289,725	923,990	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-67,992	-39,430	-28,562	-67,992	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-79,590	-46,616	-32,974	-79,590	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	36,726	36,726	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0165	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/31/2019 10:59 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,204	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	9,629,986	2.00
3.00	OPPS payments	9,617,217	3.00
4.00	Outlier payment (see instructions)	38,511	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)	9,204	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	32,326	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)	32,326	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)	32,326	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	23,122	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)	9,204	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)	9,655,728	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,886,517	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)	7,778,415	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)	7,778,415	30.00
31.00	Primary payer payments	535	31.00
32.00	Subtotal (line 30 minus line 31)	7,777,880	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)	247,724	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	161,021	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	150,152	36.00
37.00	Subtotal (see instructions)	7,938,901	37.00
38.00	MSP-LCC reconciliation amount from PS&R	25	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)	7,938,876	40.00
40.01	Sequestration adjustment (see instructions)	158,778	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	7,615,466	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	164,632	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/31/2019 10:59 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,455,512		7,615,466	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		10,455,512		7,615,466	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		79,377		164,632	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		10,534,889		7,780,098	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: 15-0165	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/31/2019 10:59 am
	Title XVIII	Hospital	PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/31/2019 10:59 am

		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	199,704,615	0	0	0	1.00
2.00	Temporary investments	4,315,385	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	18,105,731	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,428,503	0	0	0	6.00
7.00	Inventory	1,875,759	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	369,116	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)	220,942,103	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	7,941,227	0	0	0	12.00
13.00	Land improvements	2,690,295	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	80,347,339	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	5,034,517	0	0	0	17.00
18.00	Accumulated depreciation	-3,539,671	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	99,961,907	0	0	0	23.00
24.00	Accumulated depreciation	-38,077,674	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)	154,357,940	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,803,554	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,803,554	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	379,103,597	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,690,114	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,986,552	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	802,000	0	0	0	43.00
44.00	Other current liabilities	318,072,651	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	328,551,317	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	776,710	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	776,710	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	329,328,027	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	49,775,570				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)	49,775,570	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	379,103,597	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/31/2019 10:59 am

		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		43,884,328		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,823,426				2.00
3.00	Total (sum of line 1 and line 2)		57,707,754		0		3.00
4.00	ROUNDING	15		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		15		0		10.00
11.00	Subtotal (line 3 plus line 10)		57,707,769		0		11.00
12.00	EQUITY TRANSFERS	7,932,199		0		0	12.00
13.00	ROUNDING	6		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)		7,932,205		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		49,775,564		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	ROUNDING		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	EQUITY TRANSFERS		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: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/31/2019 10:59 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	17,827,378		17,827,378	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	17,827,378		17,827,378	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	4,958,444		4,958,444	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)	4,958,444		4,958,444	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,785,822		22,785,822	17.00
18.00	Ancillary services	84,942,227	207,521,158	292,463,385	18.00
19.00	Outpatient services	7,371,115	39,001,480	46,372,595	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRIVATE OFFICES	0	1,795,747	1,795,747	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	115,099,164	248,318,385	363,417,549	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		87,364,721		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)		87,364,721		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0165 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/31/2019 10:59 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	363,417,549	1.00
2.00	Less contractual allowances and discounts on patients' accounts	265,512,123	2.00
3.00	Net patient revenues (line 1 minus line 2)	97,905,426	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	87,364,721	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,540,705	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	11,836	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	526,758	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	275,654	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	2,773	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	54,305	20.00
21.00	Rental of vending machines	8,289	21.00
22.00	Rental of hospital space	272,076	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	2,131,030	24.00
25.00	Total other income (sum of lines 6-24)	3,282,721	25.00
26.00	Total (line 5 plus line 25)	13,823,426	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)	13,823,426	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0165	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/31/2019 10:59 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	873,743	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	50,247	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	31.39	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	923,990	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00