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: 15-1306	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/28/2019 12:19 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/28/2019 Time: 12:19 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH PAOLI HOSPITAL (15-1306) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MICHAEL CRAIG
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-165,599	-2,093	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	-26,237	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	-191,836	-2,093	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: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:19 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 642 WEST HOSPITAL ROAD	PO Box:			1.00
2.00	City: PAOLI	State: IN	Zip Code: 47454	County: ORANGE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	IU HEALTH PAOLI HOSPITAL	151306	99915	1	07/01/2001	N	O	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	IUHP SWING BEDS	15Z306	99915		07/01/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:19 pm

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2019 12:19 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:19 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:19 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:19 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	43,104	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:19 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: INDIANA UNIVERSITY HEALTH	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST TENTH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46204	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)	1	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)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/28/2019 12:19 pm

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 12:19 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA		UTTER		41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093		RUTTER@IUHEALTH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1306	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 12:19 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/28/2019 12:19 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	24	8,760	13,968.00	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)		24	8,760	13,968.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	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	43.00				0	13.00
14.00	Total (see instructions)		24	8,760	13,968.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		24				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: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2019 12:19 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	178	28	582			1.00
2.00	HMO and other (see instructions)	48	280				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	92	0	92			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	35			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	270	28	709			7.00
8.00	INTENSIVE CARE UNIT	0	0	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		31	207			13.00
14.00	Total (see instructions)	270	59	916	0.00	125.54	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			12			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	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	125.54	27.00
28.00	Observation Bed Days		11	694			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: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2019 12:19 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	64	23	360	1.00
2.00	HMO and other (see instructions)			18	140		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	64	23	360	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/28/2019 12:19 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.371627	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,185,281	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	15,985,325	6.00
7.00	Medicaid cost (line 1 times line 6)	5,940,578	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)	1,755,297	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)	1,755,297	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,732,016	62,526	1,794,542	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	643,664	62,526	706,190	21.00
22.00	Payments received from patients for amounts previously written off as charity care	6,877	1,400	8,277	22.00
23.00	Cost of charity care (line 21 minus line 22)	636,787	61,126	697,913	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,846,489	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	837,267	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,288,103	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,558,386	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,029,974	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,727,887	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,483,184	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	547,892	547,892	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	870,988	870,988	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,761	176,795	189,556	1,395,018	1,584,574	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	428,028	6,390,580	6,818,608	-151,675	6,666,933	5.00
7.00	00700	OPERATION OF PLANT	385,014	1,429,334	1,814,348	-678,959	1,135,389	7.00
7.01	00701	UTILITIES	0	0	0	360,291	360,291	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	62,677	62,677	0	62,677	8.00
9.00	00900	HOUSEKEEPING	179,224	143,759	322,983	-76,890	246,093	9.00
10.00	01000	DIETARY	204,522	165,878	370,400	-241,958	128,442	10.00
11.00	01100	CAFETERIA	0	0	0	161,371	161,371	11.00
13.00	01300	NURSING ADMINISTRATION	659,598	858,550	1,518,148	-243,151	1,274,997	13.00
13.01	01301	HOUSE SUPERVISORS	410,672	94,609	505,281	-63,758	441,523	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	43,801	43,801	293,490	337,291	14.00
15.00	01500	PHARMACY	228,707	1,619,401	1,848,108	-1,361,576	486,532	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,810	13,810	-4,050	9,760	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	342,377	79,046	421,423	-43,625	377,798	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	965,867	559,955	1,525,822	-486,259	1,039,563	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	163,956	22,597	186,553	-107,992	78,561	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	445,008	342,895	787,903	-265,435	522,468	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,130	0	56,130	165,418	221,548	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	811,926	1,085,361	1,897,287	-627,079	1,270,208	54.00
60.00	06000	LABORATORY	0	1,258,909	1,258,909	-1,589	1,257,320	60.00
64.00	06400	INTRAVENOUS THERAPY	68,870	37,906	106,776	-23,878	82,898	64.00
65.00	06500	RESPIRATORY THERAPY	327,980	130,741	458,721	-81,570	377,151	65.00
66.00	06600	PHYSICAL THERAPY	568,332	323,577	891,909	-390,838	501,071	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	100,365	100,365	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	20,623	20,623	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49,320	49,320	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,531	3,531	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,296,108	1,296,108	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	267	3,815	4,082	-3,794	288	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	32,305	26,713	59,018	-1,303	57,715	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,228,265	1,504,158	2,732,423	-394,809	2,337,614	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,519,809	16,374,867	23,894,676	14,227	23,908,903	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	9,051	174,606	183,657	-4,963	178,694	190.01
190.02	19002	OUTREACH	0	3,241	3,241	-282	2,959	190.02
190.03	19003	FOUNDATION	0	51	51	0	51	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	6,825	6,825	-2,224	4,601	190.05
190.06	19006	OTHER PROPERTY	0	6,758	6,758	-6,758	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	7,528,860	16,566,348	24,095,208	0	24,095,208	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-195,214	352,678		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-129,414	741,574		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-45,240	1,539,334		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-931,035	5,735,898		5.00
7.00	00700	OPERATION OF PLANT	-22,888	1,112,501		7.00
7.01	00701	UTILITIES	0	360,291		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	62,677		8.00
9.00	00900	HOUSEKEEPING	0	246,093		9.00
10.00	01000	DIETARY	0	128,442		10.00
11.00	01100	CAFETERIA	-47,331	114,040		11.00
13.00	01300	NURSING ADMINISTRATION	-226,984	1,048,013		13.00
13.01	01301	HOUSE SUPERVISORS	0	441,523		13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	337,291		14.00
15.00	01500	PHARMACY	-15,627	470,905		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,506	7,254		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-96,222	281,576		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,645	1,036,918		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	78,561		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	522,468		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	221,548		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-31	1,270,177		54.00
60.00	06000	LABORATORY	0	1,257,320		60.00
64.00	06400	INTRAVENOUS THERAPY	0	82,898		64.00
65.00	06500	RESPIRATORY THERAPY	0	377,151		65.00
66.00	06600	PHYSICAL THERAPY	-22,050	479,021		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	100,365		67.00
68.00	06800	SPEECH PATHOLOGY	0	20,623		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	49,320		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,531		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,003	1,297,111		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	CARDIAC REHAB	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	288		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	18,645	76,360		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0		90.01
91.00	09100	EMERGENCY	-160,376	2,177,238		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,877,915	22,030,988		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	178,694		190.01
190.02	19002	OUTREACH	0	2,959		190.02
190.03	19003	FOUNDATION	0	51		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	4,601		190.05
190.06	19006	OTHER PROPERTY	0	0		190.06
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,877,915	22,217,293		200.00

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 12:19 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,395,821	1.00
2.00	OUTREACH	190.02	0	64	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
	0		0	1,395,885	
	B - BILLABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,296,108	1.00
2.00		0.00	0	0	2.00
	0		0	1,296,108	
	C - BILLABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	49,320	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	0		0	49,320	
	D - CAPITAL RELATED COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	378,312	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	870,988	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
	0		0	1,249,300	
	E - IMPLANT SUPPLIES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,531	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	3,531	
	F - LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	169,580	1.00
	0		0	169,580	

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 12:19 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	G - NON-BILLABLE DRUGS				
1.00	PHARMACY	15.00	0	28,150	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
	0		0	28,150	
	H - NON-BILLABE MED SUPPLIES				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	113	1.00
2.00	OPERATION OF PLANT	7.00	0	267	2.00
3.00	NURSING ADMINISTRATION	13.00	0	61	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	296,412	4.00
5.00	CARDIAC REHABILITATION	76.97	0	2	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
	0		0	296,855	
	I - COO/CNO				
1.00	ADMINISTRATIVE & GENERAL	5.00	158,039	0	1.00
	0		158,039	0	
	J - UTILITIES				
1.00	UTILITIES	7.01	0	360,291	1.00
	0		0	360,291	
	L - OBSTETRICS				
1.00	NURSERY	43.00	0	9,466	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	137,991	27,427	2.00
	0		137,991	36,893	
	M - CAFETERIA				
1.00	CAFETERIA	11.00	113,880	47,491	1.00
	0		113,880	47,491	
	N - OT AND ST				
1.00	OCCUPATIONAL THERAPY	67.00	91,697	8,668	1.00
2.00	SPEECH PATHOLOGY	68.00	18,842	1,781	2.00
	TOTALS		110,539	10,449	
500.00	Grand Total: Increases		520,449	4,943,853	500.00

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 12:19 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	43,783	0		1.00
2.00	OPERATION OF PLANT	7.00	0	70,560	0		2.00
3.00	HOUSEKEEPING	9.00	0	73,447	0		3.00
4.00	DIETARY	10.00	0	72,620	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	83,251	0		5.00
6.00	HOUSE SUPERVISORS	13.01	0	63,758	0		6.00
7.00	PHARMACY	15.00	0	48,142	0		7.00
8.00	NONPHYSICIAN ANESTHETISTS	19.00	0	22,307	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	303,151	0		9.00
10.00	OPERATING ROOM	50.00	0	98,723	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	115,849	0		11.00
12.00	INTRAVENOUS THERAPY	64.00	0	14,521	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	46,362	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	111,032	0		14.00
15.00	CARDIAC REHABILITATION	76.97	0	11	0		15.00
16.00	CLINIC	90.00	0	1,303	0		16.00
17.00	EMERGENCY	91.00	0	225,871	0		17.00
18.00	VISITING SPECIALTY CLINIC	190.01	0	1,194	0		18.00
	0		0	1,395,885			
	B - BILLABLE DRUGS						
1.00	PHARMACY	15.00	0	1,284,931	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,177	0		2.00
	0		0	1,296,108			
	C - BILLABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	249	0		1.00
2.00	NONPHYSICIAN ANESTHETISTS	19.00	0	262	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	649	0		3.00
4.00	NURSERY	43.00	0	21	0		4.00
5.00	OPERATING ROOM	50.00	0	41,286	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,919	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	285	0		7.00
8.00	EMERGENCY	91.00	0	4,268	0		8.00
9.00	VISITING SPECIALTY CLINIC	190.01	0	381	0		9.00
	0		0	49,320			
	D - CAPITAL RELATED COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	803	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	96,464	9		2.00
3.00	OPERATION OF PLANT	7.00	0	248,375	0		3.00
4.00	HOUSEKEEPING	9.00	0	160	0		4.00
5.00	DIETARY	10.00	0	7,664	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	1,922	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,608	0		7.00
8.00	PHARMACY	15.00	0	33,366	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,045	0		9.00
10.00	NONPHYSICIAN ANESTHETISTS	19.00	0	18,897	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	60,958	0		11.00
12.00	NURSERY	43.00	0	2,005	0		12.00
13.00	OPERATING ROOM	50.00	0	78,953	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	450,684	0		14.00
15.00	LABORATORY	60.00	0	1,563	0		15.00
16.00	INTRAVENOUS THERAPY	64.00	0	1,605	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	26,867	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	151,981	0		18.00
19.00	CARDIAC REHABILITATION	76.97	0	3,785	0		19.00
20.00	EMERGENCY	91.00	0	46,763	0		20.00
21.00	VISITING SPECIALTY CLINIC	190.01	0	542	0		21.00
22.00	OUTREACH	190.02	0	308	0		22.00
23.00	PAOLI FAMILY PRACTICE	190.05	0	2,224	0		23.00
24.00	OTHER PROPERTY	190.06	0	6,758	0		24.00
	0		0	1,249,300			
	E - IMPLANT SUPPLIES						
1.00	PHARMACY	15.00	0	285	0		1.00
2.00	OPERATING ROOM	50.00	0	3,078	0		2.00
3.00	EMERGENCY	91.00	0	168	0		3.00
	0		0	3,531			
	F - LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	169,580	10		1.00
	0		0	169,580			
	G - NON-BILLABLE DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	65	0		1.00
2.00	NONPHYSICIAN ANESTHETISTS	19.00	0	37	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,829	0		3.00
4.00	NURSERY	43.00	0	168	0		4.00

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 12:19 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
5.00	OPERATING ROOM	50.00	0	1,810	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	15,787	0		6.00
7.00	INTRAVENOUS THERAPY	64.00	0	578	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	18	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	59	0		9.00
10.00	EMERGENCY	91.00	0	6,799	0		10.00
	0		0	28,150			
	H - NON-BILLABE MED SUPPLIES						
1.00	HOUSEKEEPING	9.00	0	3,283	0		1.00
2.00	DIETARY	10.00	0	303	0		2.00
3.00	PHARMACY	15.00	0	23,002	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	5	0		4.00
5.00	NONPHYSICIAN ANESTHETISTS	19.00	0	2,122	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	38,908	0		6.00
7.00	NURSERY	43.00	0	20,144	0		7.00
8.00	OPERATING ROOM	50.00	0	41,585	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	31,663	0		9.00
10.00	LABORATORY	60.00	0	26	0		10.00
11.00	INTRAVENOUS THERAPY	64.00	0	7,174	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	8,323	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	6,493	0		13.00
14.00	EMERGENCY	91.00	0	110,940	0		14.00
15.00	VISITING SPECIALTY CLINIC	190.01	0	2,846	0		15.00
16.00	OUTREACH	190.02	0	38	0		16.00
	0		0	296,855			
	I - COO/CNO						
1.00	NURSING ADMINISTRATION	13.00	158,039	0	0		1.00
	0		158,039	0			
	J - UTILITIES						
1.00	OPERATION OF PLANT	7.00	0	360,291	0		1.00
	0		0	360,291			
	L - OBSTETRICS						
1.00	ADULTS & PEDIATRICS	30.00	42,871	36,893	0		1.00
2.00	NURSERY	43.00	95,120	0	0		2.00
	0		137,991	36,893			
	M - CAFETERIA						
1.00	DIETARY	10.00	113,880	47,491	0		1.00
	0		113,880	47,491			
	N - OT AND ST						
1.00	PHYSICAL THERAPY	66.00	110,539	10,449	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		110,539	10,449			
500.00	Grand Total: Decreases		520,449	4,943,853			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I Date/Time Prepared: 5/28/2019 12:19 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	148,000	0	0	0	0	1.00
2.00	Land Improvements	438,464	0	0	0	0	2.00
3.00	Buildings and Fixtures	4,741,722	0	0	0	0	3.00
4.00	Building Improvements	1,416,127	369,994	0	369,994	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	10,649,460	393,070	0	393,070	1,164,990	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,393,773	763,064	0	763,064	1,164,990	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	17,393,773	763,064	0	763,064	1,164,990	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	148,000	0	1.00
2.00	Land Improvements	438,464	0	2.00
3.00	Buildings and Fixtures	4,741,722	0	3.00
4.00	Building Improvements	1,786,121	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	9,877,540	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,991,847	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	16,991,847	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/28/2019 12:19 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/28/2019 12:19 pm

	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	7,114,307	0	7,114,307	0.418689	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,877,539	0	9,877,539	0.581311	0	2.00
3.00	Total (sum of lines 1-2)	16,991,846	0	16,991,846	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	519,085	-166,407	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	741,574	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,260,659	-166,407	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	0	0	0	0	352,678	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	741,574	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,094,252	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/28/2019 12:19 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-335,987	CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,141,504			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	3,116,931			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-140,773	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-8,647	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/28/2019 12:19 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS INCOME	B	-47,331	CAFETERIA	11.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-1,527	NURSING ADMINISTRATION	13.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-2,506	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-31	RADIOLOGY-DIAGNOSTIC	54.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-22,050	PHYSICAL THERAPY	66.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	1,003	DRUGS CHARGED TO PATIENTS	73.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-120	CLINIC	90.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-2,500	EMERGENCY	91.00	0	33.08
33.09	UNWONTED SITUATIONS	B	-100	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	HAF	A	-724,331	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	ACCRUED PTO	A	-12,817	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	BENEFITS	A	-1,397,901	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	CRNA	A	-96,222	NONPHYSICIAN ANESTHETISTS	19.00	0	33.13
33.14	MARKETING	A	-2,645	ADULTS & PEDIATRICS	30.00	0	33.14
33.15	RECRUITING EXPENSE	A	-58,857	ADMINISTRATIVE & GENERAL	5.00	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,877,915				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: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/28/2019 12:19 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	140,773	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1,425,841	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	3,642,297	3,516,395	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	432,004	0	3.01
3.02	2.00	CAP REL COSTS-MVBLE EQUIP	RELATED PARTY	11,359	0	3.02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	66,916	127,279	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	807,048	878,620	3.04
3.05	7.00	OPERATION OF PLANT	RELATED PARTY	0	22,888	3.05
3.06	13.00	NURSING ADMINISTRATION	RELATED PARTY	476,621	702,078	3.06
3.07	15.00	PHARMACY	RELATED PARTY	194,121	209,748	3.07
3.08	90.00	CLINIC	RELATED PARTY	41,694	22,929	3.08
3.09	91.00	EMERGENCY	SIP ER ALLOCATION	2,353,756	995,562	3.09
3.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	1,591	1,591	3.10
3.11	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	156,328	156,328	3.11
3.12	10.00	DIETARY	SHARED EMPLOYEES	1,344	1,344	3.12
3.13	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	4,163	4,163	3.13
3.14	54.00	RADIOLOGY-DIAGNOSTIC	SHARED EMPLOYEES	67,340	67,340	3.14
3.15	60.00	LABORATORY	SHARED EMPLOYEES	1,228,002	1,228,002	3.15
3.16	65.00	RESPIRATORY THERAPY	SHARED EMPLOYEES	21,311	21,311	3.16
4.00	190.01	VISITING SPECIALTY CLINIC	SHARED EMPLOYEES	166,070	166,070	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,238,579	8,121,648	5.00

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

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

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

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

6.00	B		0.00	IU HEALTH BLOOM	0.00	6.00
7.00	B		0.00	IU HEALTH	100.00	7.00
8.00	C		0.00	IUH SIP	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: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/28/2019 12:19 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	140,773	9		1.00
2.00	1,425,841	0		2.00
3.00	125,902	0		3.00
3.01	432,004	0		3.01
3.02	11,359	9		3.02
3.03	-60,363	0		3.03
3.04	-71,572	0		3.04
3.05	-22,888	0		3.05
3.06	-225,457	0		3.06
3.07	-15,627	0		3.07
3.08	18,765	0		3.08
3.09	1,358,194	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
4.00	0	0		4.00
5.00	3,116,931			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	HOSPITAL		6.00
7.00	HOME OFFICE		7.00
8.00	PHYSICIAN GROUP		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: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/28/2019 12:19 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	625,434	625,434	0	0	0	1.00
2.00	91.00	EMERGENCY	2,181,979	1,516,070	665,909	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,807,413	2,141,504	665,909		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	625,434		1.00
2.00	91.00	EMERGENCY	0	0	0	1,516,070		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,141,504		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 12:19 pm

		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	352,678	352,678				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	741,574		741,574			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,539,334	6,294	14,062	1,559,690		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,735,898	21,015	46,951	121,617	5,925,481	5.00
7.00	00700	OPERATION OF PLANT	1,112,501	26,671	59,589	79,895	1,278,656	7.00
7.01	00701	UTILITIES	360,291	0	0	0	360,291	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	62,677	1,839	4,108	0	68,624	8.00
9.00	00900	HOUSEKEEPING	246,093	5,749	12,843	37,191	301,876	9.00
10.00	01000	DIETARY	128,442	10,002	22,346	18,809	179,599	10.00
11.00	01100	CAFETERIA	114,040	6,159	13,761	23,632	157,592	11.00
13.00	01300	NURSING ADMINISTRATION	1,048,013	8,923	19,936	104,080	1,180,952	13.00
13.01	01301	HOUSE SUPERVISORS	441,523	0	0	85,220	526,743	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	337,291	12,802	28,603	0	378,696	14.00
15.00	01500	PHARMACY	470,905	7,164	16,006	47,460	541,535	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,254	4,768	10,653	0	22,675	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	281,576	0	0	71,048	352,624	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,036,918	47,483	106,087	191,534	1,382,022	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	78,561	1,532	3,423	14,284	97,800	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	522,468	36,937	82,523	92,345	734,273	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	221,548	1,373	3,067	40,283	266,271	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,270,177	35,441	79,182	168,485	1,553,285	54.00
60.00	06000	LABORATORY	1,257,320	11,252	25,139	0	1,293,711	60.00
64.00	06400	INTRAVENOUS THERAPY	82,898	2,758	6,162	14,291	106,109	64.00
65.00	06500	RESPIRATORY THERAPY	377,151	1,740	3,889	68,060	450,840	65.00
66.00	06600	PHYSICAL THERAPY	479,021	27,609	61,684	94,998	663,312	66.00
67.00	06700	OCCUPATIONAL THERAPY	100,365	5,528	12,350	19,028	137,271	67.00
68.00	06800	SPEECH PATHOLOGY	20,623	1,134	2,533	3,910	28,200	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,320	0	0	0	49,320	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,531	0	0	0	3,531	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,297,111	0	0	0	1,297,111	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	288	0	0	55	343	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	76,360	251	561	6,704	83,876	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,177,238	24,686	55,153	254,883	2,511,960	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,030,988	309,110	690,611	1,557,812	21,934,579	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	178,694	22,774	50,881	1,878	254,227	190.01
190.02	19002	OUTREACH	2,959	2,678	0	0	5,637	190.02
190.03	19003	FOUNDATION	51	37	82	0	170	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	4,601	723	0	0	5,324	190.05
190.06	19006	OTHER PROPERTY	0	17,356	0	0	17,356	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	22,217,293	352,678	741,574	1,559,690	22,217,293	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	7.00	7.01	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	5,925,481					5.00
7.00	00700	OPERATION OF PLANT	465,059	1,743,715				7.00
7.01	00701	UTILITIES	131,041	0	491,332			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	24,959	14,434	3,059	111,076		8.00
9.00	00900	HOUSEKEEPING	109,795	45,129	9,565	0	466,365	9.00
10.00	01000	DIETARY	65,322	78,518	16,641	0	20,255	10.00
11.00	01100	CAFETERIA	57,318	48,352	10,248	0	12,473	11.00
13.00	01300	NURSING ADMINISTRATION	429,523	70,051	14,847	0	18,070	13.00
13.01	01301	HOUSE SUPERVISORS	191,581	0	0	0	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	137,735	100,505	21,302	0	0	14.00
15.00	01500	PHARMACY	196,961	56,243	11,920	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,247	37,431	7,933	0	9,656	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	128,253	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	502,654	372,769	79,008	29,813	96,159	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	35,571	12,028	2,549	0	3,103	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	267,062	289,970	61,457	5,806	74,801	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	96,845	10,777	2,284	2,439	2,780	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	564,944	278,230	58,969	15,693	71,772	54.00
60.00	06000	LABORATORY	470,534	88,333	18,722	0	22,786	60.00
64.00	06400	INTRAVENOUS THERAPY	38,593	21,650	4,589	0	5,585	64.00
65.00	06500	RESPIRATORY THERAPY	163,975	13,664	2,896	0	3,525	65.00
66.00	06600	PHYSICAL THERAPY	241,253	7,698	45,937	5,001	55,911	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,927	1,540	9,198	1,005	11,195	67.00
68.00	06800	SPEECH PATHOLOGY	10,257	337	1,886	207	2,296	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,938	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,284	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	471,771	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	125	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	30,506	1,973	418	0	509	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	913,622	193,794	41,073	49,148	49,991	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,822,655	1,743,426	424,501	109,112	460,867	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	92,465	0	37,892	1,964	0	190.01
190.02	19002	OUTREACH	2,050	0	0	0	5,424	190.02
190.03	19003	FOUNDATION	62	289	61	0	74	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	1,936	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	6,313	0	28,878	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	5,925,481	1,743,715	491,332	111,076	466,365	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	HOUSE SUPERVISORS	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	13.00	13.01	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
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	360,335					10.00
11.00	01100	CAFETERIA	0	285,983				11.00
13.00	01300	NURSING ADMINISTRATION	0	20,110	1,733,553			13.00
13.01	01301	HOUSE SUPERVISORS	0	14,404	0	732,728		13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	638,238	14.00
15.00	01500	PHARMACY	0	10,885	0	0	41,716	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	9	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	5,672	0	0	3,820	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	360,335	44,593	669,172	282,841	70,788	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	2,365	37,601	15,893	35,715	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	17,239	219,969	92,975	88,347	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,667	106,064	44,831	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,618	3,780	1,598	57,053	54.00
60.00	06000	LABORATORY	0	34,741	0	0	46	60.00
64.00	06400	INTRAVENOUS THERAPY	0	2,418	38,465	16,258	12,954	64.00
65.00	06500	RESPIRATORY THERAPY	0	15,185	0	0	14,828	65.00
66.00	06600	PHYSICAL THERAPY	0	17,907	0	0	9,327	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,587	0	0	1,968	67.00
68.00	06800	SPEECH PATHOLOGY	0	737	0	0	404	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	86,349	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,180	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	12	194	82	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	714	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	56,840	656,991	277,693	203,036	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	360,335	285,694	1,732,236	732,171	632,540	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	289	1,317	557	5,371	190.01
190.02	19002	OUTREACH	0	0	0	0	327	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	360,335	285,983	1,733,553	732,728	638,238	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
13.01	01301	HOUSE SUPERVISORS						13.01
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	859,260					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	85,951				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	24	0	0	490,393		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,836	8,029	0	0	3,900,019	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	109	432	0	0	243,166	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,174	6,789	0	490,393	2,350,255	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,890	0	0	540,848	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,244	14,480	0	0	2,661,666	54.00
60.00	06000	LABORATORY	0	7,475	0	0	1,936,348	60.00
64.00	06400	INTRAVENOUS THERAPY	375	2,309	0	0	249,305	64.00
65.00	06500	RESPIRATORY THERAPY	12	1,837	0	0	666,762	65.00
66.00	06600	PHYSICAL THERAPY	31	2,188	0	0	1,048,565	66.00
67.00	06700	OCCUPATIONAL THERAPY	6	395	0	0	216,092	67.00
68.00	06800	SPEECH PATHOLOGY	1	55	0	0	44,380	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	352	0	0	153,959	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	120	0	0	11,115	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	841,036	11,070	0	0	2,620,988	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	756	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	63	0	0	118,059	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,412	28,467	0	0	4,987,027	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	859,260	85,951	0	490,393	21,749,310	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	394,082	190.01
190.02	19002	OUTREACH	0	0	0	0	13,438	190.02
190.03	19003	FOUNDATION	0	0	0	0	656	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	7,260	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	52,547	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	859,260	85,951	0	490,393	22,217,293	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	UTILITIES				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
13.01	01301	HOUSE SUPERVISORS				13.01
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,900,019		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	243,166		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,350,255		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	540,848		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,661,666		54.00
60.00	06000	LABORATORY	0	1,936,348		60.00
64.00	06400	INTRAVENOUS THERAPY	0	249,305		64.00
65.00	06500	RESPIRATORY THERAPY	0	666,762		65.00
66.00	06600	PHYSICAL THERAPY	0	1,048,565		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	216,092		67.00
68.00	06800	SPEECH PATHOLOGY	0	44,380		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	153,959		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,115		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,620,988		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	CARDIAC REHAB	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	756		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	118,059		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	4,987,027		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	21,749,310		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	394,082		190.01
190.02	19002	OUTREACH	0	13,438		190.02
190.03	19003	FOUNDATION	0	656		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	7,260		190.05
190.06	19006	OTHER PROPERTY	0	52,547		190.06
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	22,217,293		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,294	14,062	20,356	20,356	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	21,015	46,951	67,966	1,587	5.00
7.00	00700	OPERATION OF PLANT	0	26,671	59,589	86,260	1,043	7.00
7.01	00701	UTILITIES	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,839	4,108	5,947	0	8.00
9.00	00900	HOUSEKEEPING	0	5,749	12,843	18,592	485	9.00
10.00	01000	DIETARY	0	10,002	22,346	32,348	245	10.00
11.00	01100	CAFETERIA	0	6,159	13,761	19,920	308	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,923	19,936	28,859	1,358	13.00
13.01	01301	HOUSE SUPERVISORS	0	0	0	0	1,112	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,802	28,603	41,405	0	14.00
15.00	01500	PHARMACY	0	7,164	16,006	23,170	619	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,768	10,653	15,421	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	927	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	47,483	106,087	153,570	2,499	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	1,532	3,423	4,955	186	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	36,937	82,523	119,460	1,205	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,373	3,067	4,440	526	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,441	79,182	114,623	2,199	54.00
60.00	06000	LABORATORY	0	11,252	25,139	36,391	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	2,758	6,162	8,920	186	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,740	3,889	5,629	888	65.00
66.00	06600	PHYSICAL THERAPY	0	27,609	61,684	89,293	1,240	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,528	12,350	17,878	248	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,134	2,533	3,667	51	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	1	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	251	561	812	87	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	24,686	55,153	79,839	3,331	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	309,110	690,611	999,721	20,331	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	22,774	50,881	73,655	25	190.01
190.02	19002	OUTREACH	0	2,678	0	2,678	0	190.02
190.03	19003	FOUNDATION	0	37	82	119	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	723	0	723	0	190.05
190.06	19006	OTHER PROPERTY	0	17,356	0	17,356	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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	352,678	741,574	1,094,252	20,356	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	7.00	7.01	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	69,553					5.00
7.00	00700	OPERATION OF PLANT	5,459	92,762				7.00
7.01	00701	UTILITIES	1,538	0	1,538			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	293	768	10	7,018		8.00
9.00	00900	HOUSEKEEPING	1,289	2,401	30	0	22,797	9.00
10.00	01000	DIETARY	767	4,177	52	0	990	10.00
11.00	01100	CAFETERIA	673	2,572	32	0	610	11.00
13.00	01300	NURSING ADMINISTRATION	5,041	3,727	46	0	883	13.00
13.01	01301	HOUSE SUPERVISORS	2,249	0	0	0	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	1,617	5,347	67	0	0	14.00
15.00	01500	PHARMACY	2,312	2,992	37	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	97	1,991	25	0	472	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,505	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,900	19,830	247	1,884	4,701	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	418	640	8	0	152	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,135	15,426	192	367	3,656	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,137	573	7	154	136	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,631	14,801	185	991	3,508	54.00
60.00	06000	LABORATORY	5,523	4,699	59	0	1,114	60.00
64.00	06400	INTRAVENOUS THERAPY	453	1,152	14	0	273	64.00
65.00	06500	RESPIRATORY THERAPY	1,925	727	9	0	172	65.00
66.00	06600	PHYSICAL THERAPY	2,832	410	144	316	2,733	66.00
67.00	06700	OCCUPATIONAL THERAPY	586	82	29	63	547	67.00
68.00	06800	SPEECH PATHOLOGY	120	18	6	13	112	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	211	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,537	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	1	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	358	105	1	0	25	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	10,724	10,309	129	3,106	2,444	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	68,346	92,747	1,329	6,894	22,528	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	1,085	0	119	124	0	190.01
190.02	19002	OUTREACH	24	0	0	0	265	190.02
190.03	19003	FOUNDATION	1	15	0	0	4	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	23	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	74	0	90	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	69,553	92,762	1,538	7,018	22,797	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	HOUSE SUPERVISORS	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	13.00	13.01	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
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	38,579					10.00
11.00	01100	CAFETERIA	0	24,115				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,696	41,610			13.00
13.01	01301	HOUSE SUPERVISORS	0	1,215	0	4,576		13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	48,436	14.00
15.00	01500	PHARMACY	0	918	0	0	3,166	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	478	0	0	290	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,579	3,760	16,060	1,766	5,372	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	199	903	99	2,710	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,454	5,280	581	6,705	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	562	2,546	280	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,666	91	10	4,330	54.00
60.00	06000	LABORATORY	0	2,929	0	0	3	60.00
64.00	06400	INTRAVENOUS THERAPY	0	204	923	102	983	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,280	0	0	1,125	65.00
66.00	06600	PHYSICAL THERAPY	0	1,510	0	0	708	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	302	0	0	149	67.00
68.00	06800	SPEECH PATHOLOGY	0	62	0	0	31	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	6,553	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	469	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	1	5	1	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	60	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	4,795	15,770	1,734	15,408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,579	24,091	41,578	4,573	48,003	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	24	32	3	408	190.01
190.02	19002	OUTREACH	0	0	0	0	25	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	38,579	24,115	41,610	4,576	48,436	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
13.01	01301	HOUSE SUPERVISORS						13.01
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	33,214					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,007				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1	0	0	3,201		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71	1,683	0		255,922	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	4	90	0		10,364	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45	1,423	0		158,929	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	396	0		10,757	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	396	3,036	0		153,467	54.00
60.00	06000	LABORATORY	0	1,567	0		52,285	60.00
64.00	06400	INTRAVENOUS THERAPY	14	484	0		13,708	64.00
65.00	06500	RESPIRATORY THERAPY	0	385	0		12,140	65.00
66.00	06600	PHYSICAL THERAPY	1	459	0		99,646	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	83	0		19,967	67.00
68.00	06800	SPEECH PATHOLOGY	0	12	0		4,092	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	74	0		6,838	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25	0		509	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,511	2,321	0		40,369	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0		0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0		0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		0	75.00
75.01	07501	CARDIAC REHAB	0	0	0		0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0		9	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	89.00
90.00	09000	CLINIC	0	13	0		1,461	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0		0	90.01
91.00	09100	EMERGENCY	171	5,956	0		153,716	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0		0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,214	18,007	0	0	994,179	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0		75,475	190.01
190.02	19002	OUTREACH	0	0	0		2,992	190.02
190.03	19003	FOUNDATION	0	0	0		139	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0		0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0		746	190.05
190.06	19006	OTHER PROPERTY	0	0	0		17,520	190.06
191.00	19100	RESEARCH	0	0	0		0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		0	192.00
193.00	19300	NONPAID WORKERS	0	0	0		0	193.00
200.00		Cross Foot Adjustments				3,201	3,201	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	33,214	18,007	0	3,201	1,094,252	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	UTILITIES				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
13.01	01301	HOUSE SUPERVISORS				13.01
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	255,922		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	10,364		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	158,929		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,757		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	153,467		54.00
60.00	06000	LABORATORY	0	52,285		60.00
64.00	06400	INTRAVENOUS THERAPY	0	13,708		64.00
65.00	06500	RESPIRATORY THERAPY	0	12,140		65.00
66.00	06600	PHYSICAL THERAPY	0	99,646		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	19,967		67.00
68.00	06800	SPEECH PATHOLOGY	0	4,092		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,838		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	509		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	40,369		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	CARDIAC REHAB	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	9		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	1,461		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	153,716		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	994,179		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	75,475		190.01
190.02	19002	OUTREACH	0	2,992		190.02
190.03	19003	FOUNDATION	0	139		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	746		190.05
190.06	19006	OTHER PROPERTY	0	17,520		190.06
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		Cross Foot Adjustments	0	3,201		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,094,252		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	57,547					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		54,160				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,027	1,027	7,516,099			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,429	3,429	586,067	-5,925,481	16,291,812	5.00
7.00	00700	OPERATION OF PLANT	4,352	4,352	385,014	0	1,278,656	7.00
7.01	00701	UTILITIES	0	0	0	0	360,291	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	300	300	0	0	68,624	8.00
9.00	00900	HOUSEKEEPING	938	938	179,224	0	301,876	9.00
10.00	01000	DIETARY	1,632	1,632	90,642	0	179,599	10.00
11.00	01100	CAFETERIA	1,005	1,005	113,880	0	157,592	11.00
13.00	01300	NURSING ADMINISTRATION	1,456	1,456	501,559	0	1,180,952	13.00
13.01	01301	HOUSE SUPERVISORS	0	0	410,672	0	526,743	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	2,089	2,089	0	0	378,696	14.00
15.00	01500	PHARMACY	1,169	1,169	228,707	0	541,535	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	778	778	0	0	22,675	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	342,377	0	352,624	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,748	7,748	922,996	0	1,382,022	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	250	250	68,836	0	97,800	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,027	6,027	445,008	0	734,273	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	224	224	194,121	0	266,271	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,783	5,783	811,926	0	1,553,285	54.00
60.00	06000	LABORATORY	1,836	1,836	0	0	1,293,711	60.00
64.00	06400	INTRAVENOUS THERAPY	450	450	68,870	0	106,109	64.00
65.00	06500	RESPIRATORY THERAPY	284	284	327,980	0	450,840	65.00
66.00	06600	PHYSICAL THERAPY	4,505	4,505	457,793	0	663,312	66.00
67.00	06700	OCCUPATIONAL THERAPY	902	902	91,697	0	137,271	67.00
68.00	06800	SPEECH PATHOLOGY	185	185	18,842	0	28,200	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	49,320	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,531	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,297,111	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	267	0	343	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	41	41	32,305	0	83,876	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,028	4,028	1,228,265	0	2,511,960	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,438	50,438	7,507,048	-5,925,481	16,009,098	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	3,716	3,716	9,051	0	254,227	190.01
190.02	19002	OUTREACH	437	0	0	0	5,637	190.02
190.03	19003	FOUNDATION	6	6	0	0	170	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	118	0	0	0	5,324	190.05
190.06	19006	OTHER PROPERTY	2,832	0	0	0	17,356	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	352,678	741,574	1,559,690		5,925,481	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.128521	13.692282	0.207513		0.363709	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			20,356		69,553	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002708		0.004269	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: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	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
7.00	00700	OPERATION OF PLANT	36,243					7.00
7.01	00701	UTILITIES	0	48,184				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	300	300	14,482			8.00
9.00	00900	HOUSEKEEPING	938	938	0	37,577		9.00
10.00	01000	DIETARY	1,632	1,632	0	1,632	4,345	10.00
11.00	01100	CAFETERIA	1,005	1,005	0	1,005	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,456	1,456	0	1,456	0	13.00
13.01	01301	HOUSE SUPERVISORS	0	0	0	0	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	2,089	2,089	0	0	0	14.00
15.00	01500	PHARMACY	1,169	1,169	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	778	778	0	778	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,748	7,748	3,887	7,748	4,345	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	250	250	0	250	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,027	6,027	757	6,027	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	224	224	318	224	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,783	5,783	2,046	5,783	0	54.00
60.00	06000	LABORATORY	1,836	1,836	0	1,836	0	60.00
64.00	06400	INTRAVENOUS THERAPY	450	450	0	450	0	64.00
65.00	06500	RESPIRATORY THERAPY	284	284	0	284	0	65.00
66.00	06600	PHYSICAL THERAPY	160	4,505	652	4,505	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	32	902	131	902	0	67.00
68.00	06800	SPEECH PATHOLOGY	7	185	27	185	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	41	41	0	41	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,028	4,028	6,408	4,028	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,237	41,630	14,226	37,134	4,345	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	3,716	256	0	0	190.01
190.02	19002	OUTREACH	0	0	0	437	0	190.02
190.03	19003	FOUNDATION	6	6	0	6	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	2,832	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	1,743,715	491,332	111,076	466,365	360,335	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.111773	10.196995	7.669935	12.410916	82.930955	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	92,762	1,538	7,018	22,797	38,579	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	8.00	9.00	10.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	2.559446	0.031919	0.484602	0.606674	8.878941	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: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	HOUSE SUPERVISORS (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	13.00	13.01	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
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	210,656					11.00
13.00	01300	NURSING ADMINISTRATION	14,813	80,267				13.00
13.01	01301	HOUSE SUPERVISORS	10,610	0	80,267			13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	364,541		14.00
15.00	01500	PHARMACY	8,018	0	0	23,827	1,324,194	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	5	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	4,178	0	0	2,182	37	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,847	30,984	30,984	40,432	2,829	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	1,742	1,741	1,741	20,399	168	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,698	10,185	10,185	50,461	1,810	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,911	4,911	4,911	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,290	175	175	32,587	15,787	54.00
60.00	06000	LABORATORY	25,590	0	0	26	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,781	1,781	1,781	7,399	578	64.00
65.00	06500	RESPIRATORY THERAPY	11,185	0	0	8,469	18	65.00
66.00	06600	PHYSICAL THERAPY	13,190	0	0	5,327	48	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,642	0	0	1,124	10	67.00
68.00	06800	SPEECH PATHOLOGY	543	0	0	231	2	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49,320	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,530	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,296,108	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	9	9	9	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	526	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	41,870	30,420	30,420	115,967	6,799	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	210,443	80,206	80,206	361,286	1,324,194	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	213	61	61	3,068	0	190.01
190.02	19002	OUTREACH	0	0	0	187	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	285,983	1,733,553	732,728	638,238	859,260	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.357583	21.597331	9.128633	1.750799	0.648893	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,115	41,610	4,576	48,436	33,214	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	HOUSE SUPERVISORS (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	13.00	13.01	14.00	15.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.114476	0.518395	0.057010	0.132868	0.025082	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: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	UTILITIES					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
13.01	01301	HOUSE SUPERVISORS					13.01
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	58,524,629				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,465,689	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	293,795	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,621,537	0	100		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,286,310	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,857,002	0	0		54.00
60.00	06000	LABORATORY	5,088,451	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	1,571,985	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	1,250,702	0	0		65.00
66.00	06600	PHYSICAL THERAPY	1,489,629	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	268,769	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	37,409	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	239,701	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81,564	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,535,759	0	0		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	CARDIAC REHAB	0	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	42,753	0	0		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0		90.01
91.00	09100	EMERGENCY	19,393,574	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,524,629	0	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0		190.01
190.02	19002	OUTREACH	0	0	0		190.02
190.03	19003	FOUNDATION	0	0	0		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0		190.05
190.06	19006	OTHER PROPERTY	0	0	0		190.06
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
193.00	19300	NONPAID WORKERS	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)	85,951	0	490,393		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001469	0.000000	4,903.930000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,007	0	3,201		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:19 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000308	0.000000	32.010000		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: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,900,019		3,900,019	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	243,166		243,166	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,350,255		2,350,255	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	540,848		540,848	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,661,666		2,661,666	0	0	54.00
60.00	06000	LABORATORY	1,936,348		1,936,348	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	249,305		249,305	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	666,762	0	666,762	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,048,565	0	1,048,565	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	216,092	0	216,092	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	44,380	0	44,380	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	153,959		153,959	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,115		11,115	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,620,988		2,620,988	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0		0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	CARDIAC REHAB	0		0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	756		756	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	118,059		118,059	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0		0	0	0	90.01
91.00	09100	EMERGENCY	4,987,027		4,987,027	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,976,227		1,976,227		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	23,725,537	0	23,725,537	0	0	200.00
201.00		Less Observation Beds	1,976,227		1,976,227		0	201.00
202.00		Total (see instructions)	21,749,310	0	21,749,310	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,373,721		1,373,721			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	293,795		293,795			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	795,264	3,826,273	4,621,537	0.508544	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	910,994	375,316	1,286,310	0.420465	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,265	9,758,737	9,857,002	0.270028	0.000000	54.00
60.00	06000	LABORATORY	252,267	4,836,184	5,088,451	0.380538	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,571,985	1,571,985	0.158592	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	127,321	1,123,381	1,250,702	0.533110	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	68,896	1,420,733	1,489,629	0.703910	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,984	244,785	268,769	0.804006	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	37,409	37,409	1.186346	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,245	199,456	239,701	0.642296	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	81,564	81,564	0.136273	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	575,484	6,960,275	7,535,759	0.347807	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0.000000	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	42,753	42,753	2.761420	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	165,208	19,228,366	19,393,574	0.257148	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	27,750	4,064,218	4,091,968	0.482953	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,753,194	53,771,435	58,524,629			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,753,194	53,771,435	58,524,629			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501	CARDIAC REHAB	0.000000		75.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		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: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 12:19 pm

Title XIX | Hospital | PPS

		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	3,900,019		3,900,019	0	3,900,019	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	243,166		243,166	0	243,166	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,350,255		2,350,255	0	2,350,255	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	540,848		540,848	0	540,848	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,661,666		2,661,666	0	2,661,666	54.00
60.00	06000	LABORATORY	1,936,348		1,936,348	0	1,936,348	60.00
64.00	06400	INTRAVENOUS THERAPY	249,305		249,305	0	249,305	64.00
65.00	06500	RESPIRATORY THERAPY	666,762	0	666,762	0	666,762	65.00
66.00	06600	PHYSICAL THERAPY	1,048,565	0	1,048,565	0	1,048,565	66.00
67.00	06700	OCCUPATIONAL THERAPY	216,092	0	216,092	0	216,092	67.00
68.00	06800	SPEECH PATHOLOGY	44,380	0	44,380	0	44,380	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	153,959		153,959	0	153,959	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,115		11,115	0	11,115	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,620,988		2,620,988	0	2,620,988	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0		0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	CARDIAC REHAB	0		0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	756		756	0	756	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	118,059		118,059	0	118,059	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0		0	0	0	90.01
91.00	09100	EMERGENCY	4,987,027		4,987,027	0	4,987,027	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,976,227		1,976,227		1,976,227	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	23,725,537	0	23,725,537	0	23,725,537	200.00
201.00		Less Observation Beds	1,976,227		1,976,227		1,976,227	201.00
202.00		Total (see instructions)	21,749,310	0	21,749,310	0	21,749,310	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 12:19 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,373,721		1,373,721			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	293,795		293,795			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	795,264	3,826,273	4,621,537	0.508544	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	910,994	375,316	1,286,310	0.420465	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,265	9,758,737	9,857,002	0.270028	0.000000	54.00
60.00	06000	LABORATORY	252,267	4,836,184	5,088,451	0.380538	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,571,985	1,571,985	0.158592	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	127,321	1,123,381	1,250,702	0.533110	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	68,896	1,420,733	1,489,629	0.703910	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,984	244,785	268,769	0.804006	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	37,409	37,409	1.186346	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,245	199,456	239,701	0.642296	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	81,564	81,564	0.136273	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	575,484	6,960,275	7,535,759	0.347807	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0.000000	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	42,753	42,753	2.761420	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	165,208	19,228,366	19,393,574	0.257148	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	27,750	4,064,218	4,091,968	0.482953	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,753,194	53,771,435	58,524,629			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,753,194	53,771,435	58,524,629			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 12:19 pm

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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.508544		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.420465		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.270028		54.00
60.00	06000	LABORATORY	0.380538		60.00
64.00	06400	INTRAVENOUS THERAPY	0.158592		64.00
65.00	06500	RESPIRATORY THERAPY	0.533110		65.00
66.00	06600	PHYSICAL THERAPY	0.703910		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.804006		67.00
68.00	06800	SPEECH PATHOLOGY	1.186346		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.642296		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.136273		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347807		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501	CARDIAC REHAB	0.000000		75.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	2.761420		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000		90.01
91.00	09100	EMERGENCY	0.257148		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482953		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		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: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part II | Date/Time Prepared: 5/28/2019 12:19 pm

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	2,350,255	158,929	2,191,326	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	540,848	10,757	530,091	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,661,666	153,467	2,508,199	0	0	54.00
60.00	06000	LABORATORY	1,936,348	52,285	1,884,063	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	249,305	13,708	235,597	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	666,762	12,140	654,622	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,048,565	99,646	948,919	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	216,092	19,967	196,125	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	44,380	4,092	40,288	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	153,959	6,838	147,121	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,115	509	10,606	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,620,988	40,369	2,580,619	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	756	9	747	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	118,059	1,461	116,598	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,987,027	153,716	4,833,311	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,976,227	129,682	1,846,545	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	19,582,352	857,575	18,724,777	0	0	200.00
201.00		Less Observation Beds	1,976,227	129,682	1,846,545	0	0	201.00
202.00		Total (line 200 minus line 201)	17,606,125	727,893	16,878,232	0	0	202.00

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

Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part II | Date/Time Prepared: 5/28/2019 12:19 pm

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	2,350,255	4,621,537	0.508544		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	540,848	1,286,310	0.420465		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,661,666	9,857,002	0.270028		54.00
60.00	06000	LABORATORY	1,936,348	5,088,451	0.380538		60.00
64.00	06400	INTRAVENOUS THERAPY	249,305	1,571,985	0.158592		64.00
65.00	06500	RESPIRATORY THERAPY	666,762	1,250,702	0.533110		65.00
66.00	06600	PHYSICAL THERAPY	1,048,565	1,489,629	0.703910		66.00
67.00	06700	OCCUPATIONAL THERAPY	216,092	268,769	0.804006		67.00
68.00	06800	SPEECH PATHOLOGY	44,380	37,409	1.186346		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	153,959	239,701	0.642296		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,115	81,564	0.136273		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,620,988	7,535,759	0.347807		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000		75.00
75.01	07501	CARDIAC REHAB	0	0	0.000000		75.01
76.97	07697	CARDIAC REHABILITATION	756	0	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000	CLINIC	118,059	42,753	2.761420		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0.000000		90.01
91.00	09100	EMERGENCY	4,987,027	19,393,574	0.257148		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,976,227	4,091,968	0.482953		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	19,582,352	56,857,113			200.00
201.00		Less Observation Beds	1,976,227	0			201.00
202.00		Total (line 200 minus line 201)	17,606,125	56,857,113			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	158,929	4,621,537	0.034389	25,177	866	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,757	1,286,310	0.008363	4,425	37	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	153,467	9,857,002	0.015569	23,030	359	54.00
60.00	06000	LABORATORY	52,285	5,088,451	0.010275	36,437	374	60.00
64.00	06400	INTRAVENOUS THERAPY	13,708	1,571,985	0.008720	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,140	1,250,702	0.009707	58,047	563	65.00
66.00	06600	PHYSICAL THERAPY	99,646	1,489,629	0.066893	15,604	1,044	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,967	268,769	0.074291	526	39	67.00
68.00	06800	SPEECH PATHOLOGY	4,092	37,409	0.109385	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,838	239,701	0.028527	1,173	33	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	509	81,564	0.006240	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,369	7,535,759	0.005357	128,117	686	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0.000000	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	9	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	1,461	42,753	0.034173	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	153,716	19,393,574	0.007926	25,272	200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	129,682	4,091,968	0.031692	7,270	230	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	857,575	56,857,113		325,078	4,431	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	490,393	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	490,393	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	490,393	0	4,621,537	0.106110	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,286,310	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,857,002	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	5,088,451	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,571,985	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,250,702	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,489,629	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	268,769	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	37,409	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	239,701	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	81,564	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,535,759	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	42,753	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	19,393,574	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,091,968	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	490,393	0	56,857,113		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	25,177	2,672	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	4,425	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	23,030	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	36,437	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	58,047	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	15,604	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	526	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,173	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	128,117	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0.000000	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	25,272	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	7,270	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		325,078	2,672	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.508544	0	1,264,129	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.420465	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.270028	0	3,083,969	0	0	54.00
60.00	06000	LABORATORY	0.380538	0	1,619,642	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.158592	0	500,068	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.533110	0	413,795	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.703910	0	478,355	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.804006	0	43,776	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.186346	0	445	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.642296	0	32,975	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.136273	0	43,887	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347807	0	3,214,820	3,483	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0.000000	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	2.761420	0	33,520	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.257148	0	5,378,564	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482953	0	1,943,817	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	18,051,762	3,483	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	18,051,762	3,483	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	642,865	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	832,758	0		54.00
60.00	06000	LABORATORY	616,335	0		60.00
64.00	06400	INTRAVENOUS THERAPY	79,307	0		64.00
65.00	06500	RESPIRATORY THERAPY	220,598	0		65.00
66.00	06600	PHYSICAL THERAPY	336,719	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	35,196	0		67.00
68.00	06800	SPEECH PATHOLOGY	528	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,180	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,981	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,118,137	1,211		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	CARDIAC REHAB	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	92,563	0		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0		90.01
91.00	09100	EMERGENCY	1,383,087	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	938,772	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	6,324,026	1,211		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,324,026	1,211		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.508544	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.420465	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.270028	0	0	0	0	54.00
60.00	06000	LABORATORY	0.380538	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.158592	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.533110	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.703910	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.804006	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.186346	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.642296	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.136273	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347807	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0.000000	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	2.761420	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.257148	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482953	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	CARDIAC REHAB	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/28/2019 12:19 pm

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	255,922	17,488	238,434	1,276	186.86	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
43.00	NURSERY	10,364		10,364	207	50.07	43.00
200.00	Total (lines 30 through 199)	266,286		248,798	1,483		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	28	5,232				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
43.00	NURSERY	31	1,552				43.00
200.00	Total (lines 30 through 199)	59	6,784				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/28/2019 12:19 pm

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	158,929	4,621,537	0.034389	43,560	1,498	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,757	1,286,310	0.008363	51,317	429	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	153,467	9,857,002	0.015569	11,870	185	54.00
60.00	06000	LABORATORY	52,285	5,088,451	0.010275	24,722	254	60.00
64.00	06400	INTRAVENOUS THERAPY	13,708	1,571,985	0.008720	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,140	1,250,702	0.009707	242	2	65.00
66.00	06600	PHYSICAL THERAPY	99,646	1,489,629	0.066893	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,967	268,769	0.074291	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,092	37,409	0.109385	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,838	239,701	0.028527	3,690	105	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	509	81,564	0.006240	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,369	7,535,759	0.005357	35,146	188	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0.000000	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	9	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	1,461	42,753	0.034173	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	153,716	19,393,574	0.007926	14,043	111	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	129,682	4,091,968	0.031692	2,170	69	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	857,575	56,857,113		186,760	2,841	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/28/2019 12:19 pm

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
43.00	04300	NURSERY	0	0	0	0	0	43.00
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	1,276	0.00	28	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
43.00	04300	NURSERY		0	207	0.00	31	43.00
200.00		Total (lines 30 through 199)		0	1,483		59	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
43.00	04300	NURSERY	0		43.00
200.00		Total (lines 30 through 199)	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 12:19 pm

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	490,393	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	490,393	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 12:19 pm

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	490,393	0	4,621,537	0.106110	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,286,310	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,857,002	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	5,088,451	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,571,985	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,250,702	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,489,629	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	268,769	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	37,409	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	239,701	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	81,564	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,535,759	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	42,753	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	19,393,574	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,091,968	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	490,393	0	56,857,113		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 12:19 pm

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	43,560	4,622	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	51,317	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	11,870	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	24,722	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	242	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	3,690	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	35,146	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0.000000	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	14,043	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,170	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		186,760	4,622	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,403	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,276	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)	582	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	92	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	35	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)	178	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)	92	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,900,019	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)	4,520	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)	266,498	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,633,521	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)	3,633,521	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,847.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	506,871	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)	506,871	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	132,425	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	639,296	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	261,978	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)	261,978	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)	694	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,847.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,976,227	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	255,922	3,900,019	0.065621	1,976,227	129,682	90.00
91.00	Nursing School cost	0	3,900,019	0.000000	1,976,227	0	91.00
92.00	Allied health cost	0	3,900,019	0.000000	1,976,227	0	92.00
93.00	All other Medical Education	0	3,900,019	0.000000	1,976,227	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:19 pm

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)	1,403	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,276	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)	582	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	92	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	35	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)	28	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)	207	15.00
16.00	Nursery days (title V or XIX only)	31	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,900,019	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)	4,520	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)	266,498	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,633,521	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)	3,633,521	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,847.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	79,733	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)	79,733	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:19 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	243,166	207	1,174.71	31	36,416	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	75,724	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	191,873	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)	6,784	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	7,463	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	14,247	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	177,626	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)	694	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,847.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,976,227	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:19 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	255,922	3,900,019	0.065621	1,976,227	129,682	90.00
91.00	Nursing School cost	0	3,900,019	0.000000	1,976,227	0	91.00
92.00	Allied health cost	0	3,900,019	0.000000	1,976,227	0	92.00
93.00	All other Medical Education	0	3,900,019	0.000000	1,976,227	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		346,397		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.508544	25,177	12,804	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.420465	4,425	1,861	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.270028	23,030	6,219	54.00
60.00	06000	LABORATORY	0.380538	36,437	13,866	60.00
64.00	06400	INTRAVENOUS THERAPY	0.158592	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.533110	58,047	30,945	65.00
66.00	06600	PHYSICAL THERAPY	0.703910	15,604	10,984	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.804006	526	423	67.00
68.00	06800	SPEECH PATHOLOGY	1.186346	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.642296	1,173	753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.136273	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347807	128,117	44,560	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	CARDIAC REHAB	0.000000	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	2.761420	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.257148	25,272	6,499	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482953	7,270	3,511	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		325,078	132,425	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)		325,078		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.508544	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.420465	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.270028	1,180	319	54.00
60.00	06000	LABORATORY	0.380538	5,353	2,037	60.00
64.00	06400	INTRAVENOUS THERAPY	0.158592	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.533110	2,882	1,536	65.00
66.00	06600	PHYSICAL THERAPY	0.703910	25,493	17,945	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.804006	14,440	11,610	67.00
68.00	06800	SPEECH PATHOLOGY	1.186346	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.642296	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.136273	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347807	33,454	11,636	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	CARDIAC REHAB	0.000000	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	2.761420	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.257148	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482953	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		82,802	45,083	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)		82,802		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 12:19 pm

Title XIX | 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		50,283		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		41,925		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.508544	43,560	22,152	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.420465	51,317	21,577	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.270028	11,870	3,205	54.00
60.00	06000	LABORATORY	0.380538	24,722	9,408	60.00
64.00	06400	INTRAVENOUS THERAPY	0.158592	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.533110	242	129	65.00
66.00	06600	PHYSICAL THERAPY	0.703910	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.804006	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.186346	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.642296	3,690	2,370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.136273	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347807	35,146	12,224	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	CARDIAC REHAB	0.000000	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	2.761420	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.257148	14,043	3,611	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482953	2,170	1,048	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		186,760	75,724	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)		186,760		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1306	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 12:19 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,325,237	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,325,237	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,388,489	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	42,248	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,284,518	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,061,723	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,061,723	30.00
31.00	Primary payer payments	675	31.00
32.00	Subtotal (line 30 minus line 31)	3,061,048	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,266,312	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	823,103	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,117,096	36.00
37.00	Subtotal (see instructions)	3,884,151	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,884,151	40.00
40.01	Sequestration adjustment (see instructions)	77,683	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,808,561	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-2,093	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	204,151	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: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		549,589		3,700,361	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/22/2018	191,800	08/22/2018	108,200	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		191,800		108,200	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		741,389		3,808,561	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		165,599		2,093	6.02
7.00	Total Medicare program liability (see instructions)		575,790		3,806,468	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2019 12:19 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		281,989		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/22/2018	46,700		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		46,700		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		328,689		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		26,237		0	6.02
7.00	Total Medicare program liability (see instructions)		302,452		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1306	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/28/2019 12:19 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1306 Component CCN: 15-Z306	Period: From 01/01/2018 To 12/31/2018	Worksheet E-2 Date/Time Prepared: 5/28/2019 12:19 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	264,598	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	45,534	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	92	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	310,132	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	310,132	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	310,132	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,508	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	308,624	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	308,624	0	19.00
19.01	Sequestration adjustment (see instructions)	6,172	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	328,689	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-26,237	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	9,917	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1306	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/28/2019 12:19 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	639,296	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	639,296	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	645,689	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	645,689	19.00
20.00	Deductibles (exclude professional component)	72,312	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	573,377	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	573,377	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	21,791	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	14,164	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	19,021	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	587,541	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	587,541	30.00
30.01	Sequestration adjustment (see instructions)	11,751	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	741,389	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-165,599	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	24,648	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/28/2019 12:19 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	14,521,853	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	106,804	0	0	0	3.00
4.00	Accounts receivable	2,661,135	0	0	0	4.00
5.00	Other receivable	-1,019,959	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	476,763	0	0	0	7.00
8.00	Prepaid expenses	126,792	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,873,388	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	148,000	0	0	0	12.00
13.00	Land improvements	438,464	0	0	0	13.00
14.00	Accumulated depreciation	-350,620	0	0	0	14.00
15.00	Buildings	7,320,569	0	0	0	15.00
16.00	Accumulated depreciation	-3,348,241	0	0	0	16.00
17.00	Leasehold improvements	791,602	0	0	0	17.00
18.00	Accumulated depreciation	-364,990	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	31,751	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,836,603	0	0	0	23.00
24.00	Accumulated depreciation	-6,153,242	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)	8,349,896	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	583,096	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	7,319,813	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,902,909	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,126,193	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,118,771	0	0	0	37.00
38.00	Salaries, wages, and fees payable	756,502	0	0	0	38.00
39.00	Payroll taxes payable	8,415	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,012,387	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,896,075	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	28,259	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	28,259	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,924,334	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	28,201,859				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	28,201,859	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,126,193	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/28/2019 12:19 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		35,520,144		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,983,431				2.00
3.00	Total (sum of line 1 and line 2)		33,536,713		0		3.00
4.00	ROUNDING	3		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)		3		0		10.00
11.00	Subtotal (line 3 plus line 10)		33,536,716		0		11.00
12.00	INTERCOMPANY CAPITAL TRANSFER	5,334,857		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		5,334,857		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		28,201,859		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	INTERCOMPANY CAPITAL TRANSFER		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/28/2019 12:19 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,564,391		1,564,391	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	103,124		103,124	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)	1,667,515		1,667,515	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,667,515		1,667,515	17.00
18.00	Ancillary services	2,892,720	30,436,099	33,328,819	18.00
19.00	Outpatient services	192,958	23,335,337	23,528,295	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NRCC	0	78,056	78,056	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,753,193	53,849,492	58,602,685	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,095,208		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)		24,095,208		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1306	Period: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 5/28/2019 12:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	58,602,685	1.00
2.00	Less contractual allowances and discounts on patients' accounts	36,842,974	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,759,711	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,095,208	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,335,497	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	352,066	24.00
25.00	Total other income (sum of lines 6-24)	352,066	25.00
26.00	Total (line 5 plus line 25)	-1,983,431	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)	-1,983,431	29.00