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: 15-0001	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 11:55 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2019 Time: 11:55 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JOHNSON MEMORIAL HOSPITAL (15-0001) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	146,465	-57,987	0	-63,556	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-4,459	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	142,006	-57,987	0	-63,556	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 11:55 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1125 WEST JEFFERSON STREET	PO Box:			1.00
2.00	City: FRANKLIN	State: IN	Zip Code: 46131-	County: JOHNSON	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	JOHNSON MEMORIAL HOSPITAL	150001	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	TODD AIKENS REHAB CENTER	15T001	26900	5	01/01/2005	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	JOHNSON MEMORIAL HOME HEALTH	157510	26900		07/01/1997	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	9		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.	Y	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)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 11:55 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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.	63	922	0	0	421	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	42		25.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 11:55 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 11:55 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 11:55 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 11:55 am

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	326,154	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 11:55 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2017	12/31/2017	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: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2019 11:55 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		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)	Y	04/18/2019	Y	04/18/2019
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)	N		N	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 11:55 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		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.		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.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0001	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 11:55 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		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: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 11:55 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	77	28,105	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		77	28,105	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	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)		83	30,295	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	11	4,015		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		94				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: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 11:55 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,298	55	5,455			1.00
2.00	HMO and other (see instructions)	475	1,340				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	42				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,298	55	5,455			7.00
8.00	INTENSIVE CARE UNIT	208	0	496			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		7	731			13.00
14.00	Total (see instructions)	2,506	62	6,682	0.00	581.14	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	118	0	449	0.00	0.00	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	2,532	0	5,549	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)			44			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	581.14	27.00
28.00	Observation Bed Days		0	229			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	4	51			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: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 11:55 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	705	19	1,917	1.00
2.00	HMO and other (see instructions)			113	360		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				2		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	705	19	1,917	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	10	0	30	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2019 11:55 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	40,263,393	-63,798	40,199,595	1,175,940.00	34.19	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		1,121,598	0	1,121,598	12,061.00	92.99	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		603,208	0	603,208	17,715.00	34.05	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		12,742,663	-141,443	12,601,220	232,955.00	54.09	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		77,376	0	77,376	1,017.00	76.08	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		430,767	0	430,767	1,837.00	234.49	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,529,340	0	7,529,340			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,496,581	0	2,496,581			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		148,486	0	148,486			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	3,292,822	135,520	3,428,342	160,639.00	21.34	26.00
27.00	Administrative & General	5.00	1,566,329	-51,006	1,515,323	65,068.00	23.29	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2019 11:55 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		1,917,819	0	1,917,819	15,001.00	127.85	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	619,650	0	619,650	27,525.00	22.51	30.00
31.00	Laundry & Linen Service	8.00	107,874	0	107,874	7,882.00	13.69	31.00
32.00	Housekeeping	9.00	709,799	0	709,799	51,054.00	13.90	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	744,065	-481,321	262,744	18,876.00	13.92	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	481,321	481,321	27,207.00	17.69	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,467,049	0	1,467,049	24,881.00	58.96	38.00
39.00	Central Services and Supply	14.00	90,212	0	90,212	4,596.00	19.63	39.00
40.00	Pharmacy	15.00	496,731	0	496,731	12,938.00	38.39	40.00
41.00	Medical Records & Medical Records Library	16.00	543,399	0	543,399	26,031.00	20.88	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 5/29/2019 11:55 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		40,456,406	-63,798	40,392,608	1,161,165.00	34.79	1.00
2.00	Excluded area salaries (see instructions)		12,742,663	-141,443	12,601,220	232,955.00	54.09	2.00
3.00	Subtotal salaries (line 1 minus line 2)		27,713,743	77,645	27,791,388	928,210.00	29.94	3.00
4.00	Subtotal other wages & related costs (see inst.)		508,143	0	508,143	2,854.00	178.05	4.00
5.00	Subtotal wage-related costs (see inst.)		7,529,340	0	7,529,340	0.00	27.09	5.00
6.00	Total (sum of lines 3 thru 5)		35,751,226	77,645	35,828,871	931,064.00	38.48	6.00
7.00	Total overhead cost (see instructions)		11,555,749	84,514	11,640,263	441,698.00	26.35	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 5/29/2019 11:55 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	934,063	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	6,107,785	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	26,143	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	118,071	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	234,668	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,695,776	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	18,326	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	10,662	22.00
23.00	Tuition Reimbursement	28,912	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,174,406	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 5/29/2019 11:55 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	77,376	10,174,406	1.00
2.00	Hospital	77,376	10,174,406	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0001 | Component CCN: 15-7510 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-4 | Date/Time Prepared: 5/29/2019 11:55 am

Home Health Agency I | PPS

						1.00	
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	0.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	1.53	0.00	1.53	3.00
4.00	Director(s) and Assistant Director(s)			0.13	0.00	0.13	4.00
5.00	Other Administrative Personnel			0.40	0.00	0.40	5.00
6.00	Direct Nursing Service			2.42	0.00	2.42	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			1.25	0.00	1.25	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.97	0.00	0.97	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.79	0.00	0.79	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			18020			20.00
20.01				26900			20.01
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,054	0	10	0	1,064	21.00
22.00	Skilled Nursing Visit Charges	252,960	0	2,400	0	255,360	22.00
23.00	Physical Therapy Visits	880	0	3	0	883	23.00
24.00	Physical Therapy Visit Charges	228,800	0	780	0	229,580	24.00
25.00	Occupational Therapy Visits	559	0	0	0	559	25.00
26.00	Occupational Therapy Visit Charges	145,340	0	0	0	145,340	26.00
27.00	Speech Pathology Visits	24	0	0	0	24	27.00
28.00	Speech Pathology Visit Charges	6,240	0	0	0	6,240	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	2	0	0	0	2	31.00
32.00	Home Health Aide Visit Charges	210	0	0	0	210	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,519	0	13	0	2,532	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	633,550	0	3,180	0	636,730	35.00
36.00	Total Number of Episodes (standard/non outlier)	133		5	0	138	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	3,405	0	36	0	3,441	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/29/2019 11:55 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.265004	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,288,808	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	25,157,224	6.00
7.00	Medicaid cost (line 1 times line 6)	6,666,765	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)	1,377,957	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)	1,377,957	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,750,122	904,569	3,654,691	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	728,793	904,569	1,633,362	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	728,793	904,569	1,633,362	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)	5,665,453	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	114,098	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	175,535	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,489,918	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,516,287	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,149,649	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,527,606	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		233,374	233,374	0	233,374	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,753,571	4,753,571	0	4,753,571	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	312,491	9,034,263	9,346,754	231,992	9,578,746	4.00
4.01	00401	COMMUNICATIONS	86,368	239,162	325,530	-36	325,494	4.01
4.02	00402	DATA PROCESSING	782,484	1,940,511	2,722,995	-39	2,722,956	4.02
4.03	00403	MATERIALS MANAGEMENT	321,857	45,956	367,813	-427	367,386	4.03
4.04	00404	ADMITTING	743,258	8,066	751,324	-271	751,053	4.04
4.05	00405	PATIENT ACCOUNTING	1,046,364	646,985	1,693,349	0	1,693,349	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	1,566,329	4,374,332	5,940,661	-54,772	5,885,889	5.00
7.00	00700	OPERATION OF PLANT	619,650	1,870,047	2,489,697	-96	2,489,601	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	107,874	89,283	197,157	-531	196,626	8.00
9.00	00900	HOUSEKEEPING	709,799	106,073	815,872	-3,357	812,515	9.00
10.00	01000	DIETARY	744,065	348,515	1,092,580	-707,000	385,580	10.00
11.00	01100	CAFETERIA	0	0	0	706,768	706,768	11.00
13.00	01300	NURSING ADMINISTRATION	1,467,049	204,756	1,671,805	-46	1,671,759	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	90,212	132,662	222,874	-58,975	163,899	14.00
15.00	01500	PHARMACY	496,731	4,627,807	5,124,538	-3,707,297	1,417,241	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	543,399	87,553	630,952	0	630,952	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,237,294	615,636	4,852,930	-321,890	4,531,040	30.00
31.00	03100	INTENSIVE CARE UNIT	1,197,447	107,097	1,304,544	-47,500	1,257,044	31.00
41.00	04100	SUBPROVIDER - IRF	267,599	56,603	324,202	-44,993	279,209	41.00
43.00	04300	NURSERY	0	0	0	180,150	180,150	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,868,927	446,546	2,315,473	-213,387	2,102,086	50.00
53.00	05300	ANESTHESIOLOGY	0	27,428	27,428	39,028	66,456	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,030,417	686,078	2,716,495	-75,255	2,641,240	54.00
60.00	06000	LABORATORY	1,761,381	2,203,994	3,965,375	-170,928	3,794,447	60.00
65.00	06500	RESPIRATORY THERAPY	964,235	175,188	1,139,423	-69,224	1,070,199	65.00
66.00	06600	PHYSICAL THERAPY	746,962	41,477	788,439	23,867	812,306	66.00
67.00	06700	OCCUPATIONAL THERAPY	253,582	25	253,607	0	253,607	67.00
68.00	06800	SPEECH PATHOLOGY	138,700	649	139,349	0	139,349	68.00
69.00	06900	ELECTROCARDIOLOGY	278,766	135,880	414,646	-6,672	407,974	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	49,335	8,551	57,886	-1,550	56,336	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,872,585	3,872,585	-610,287	3,262,298	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,684,761	1,684,761	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,250,199	4,250,199	73.00
76.00	03020	ONCOLOGY	262,852	194,984	457,836	-4,495	453,341	76.00
76.97	07697	CARDIAC REHABILITATION	128,438	170,539	298,977	-6,360	292,617	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	699,614	2,104,167	2,803,781	-183,381	2,620,400	90.00
91.00	09100	EMERGENCY	3,264,850	1,009,278	4,274,128	-67,223	4,206,905	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	628,642	85,231	713,873	-5,148	708,725	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)	28,416,971	40,684,852	69,101,823	755,625	69,857,448	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	49,892	29,179	79,071	-129	78,942	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,261,737	4,871,477	16,133,214	-567,486	15,565,728	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	78,615	6,202	84,817	-6,000	78,817	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	386,597	129,699	516,296	-182,009	334,287	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	21,676	35,127	56,803	-1	56,802	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	47,905	0	47,905	0	47,905	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	40,263,393	45,756,536	86,019,929	0	86,019,929	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	66,139	299,513		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	4,753,571		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-173,294	9,405,452		4.00
4.01	00401	COMMUNICATIONS	-15,282	310,212		4.01
4.02	00402	DATA PROCESSING	0	2,722,956		4.02
4.03	00403	MATERIALS MANAGEMENT	0	367,386		4.03
4.04	00404	ADMITTING	0	751,053		4.04
4.05	00405	PATIENT ACCOUNTING	-4,521	1,688,828		4.05
5.00	00500	ADMINISTRATIVE & GENERAL	-3,453,973	2,431,916		5.00
7.00	00700	OPERATION OF PLANT	-38,578	2,451,023		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	196,626		8.00
9.00	00900	HOUSEKEEPING	0	812,515		9.00
10.00	01000	DIETARY	0	385,580		10.00
11.00	01100	CAFETERIA	-299,512	407,256		11.00
13.00	01300	NURSING ADMINISTRATION	-525	1,671,234		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	163,899		14.00
15.00	01500	PHARMACY	-1,351	1,415,890		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-36,523	594,429		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,404,808	3,126,232		30.00
31.00	03100	INTENSIVE CARE UNIT	-7,683	1,249,361		31.00
41.00	04100	SUBPROVIDER - IRF	0	279,209		41.00
43.00	04300	NURSERY	0	180,150		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,102,086		50.00
53.00	05300	ANESTHESIOLOGY	0	66,456		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,641,240		54.00
60.00	06000	LABORATORY	0	3,794,447		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,070,199		65.00
66.00	06600	PHYSICAL THERAPY	-10,842	801,464		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	253,607		67.00
68.00	06800	SPEECH PATHOLOGY	-625	138,724		68.00
69.00	06900	ELECTROCARDIOLOGY	-91,111	316,863		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	56,336		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,262,298		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,684,761		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,250,199		73.00
76.00	03020	ONCOLOGY	-130,613	322,728		76.00
76.97	07697	CARDIAC REHABILITATION	-127,750	164,867		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-718,104	1,902,296		90.00
91.00	09100	EMERGENCY	-2,113,754	2,093,151		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	708,725		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,562,710	61,294,738		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	78,942		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,565,728		192.00
192.01	19201	SOUTH CLINIC	0	0		192.01
192.02	19202	WEST CLINIC	0	0		192.02
192.03	19203	DIABETES CENTER	0	78,817		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	334,287		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0		193.03
194.00	07950	PARTNERSHIP HFC	0	56,802		194.00
194.01	07951	TRAFALGAR CLINIC	0	0		194.01
194.02	07952	EDINBURGH	0	0		194.02
194.03	07953	JAIL	0	47,905		194.03
194.04	07954	ATHLETIC TRAINERS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,562,710	77,457,219		200.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 11:55 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - NURSERY RECLASS					
1.00	NURSERY	43.00	165,622	14,528		1.00
	TOTALS		165,622	14,528		
	B - IMPLANTABLE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,684,761		1.00
	TOTALS		0	1,684,761		
	C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	481,321	225,447		1.00
	TOTALS		481,321	225,447		
	D - DAY CARE RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	135,520	45,466		1.00
	TOTALS		135,520	45,466		
	G - STD RECLASS					
1.00	INTENSIVE CARE UNIT	31.00	0	6,869		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,923		2.00
	TOTALS		0	12,792		
	H - EMPLOYEE WELLNESS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	51,006		1.00
	TOTALS		0	51,006		
	J - PART A RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	19,083		1.00
2.00	PHYSICAL THERAPY	66.00	0	39,160		2.00
3.00	ANESTHESIOLOGY	53.00	0	39,039		3.00
	TOTALS		0	97,282		
	K - MEDICAL SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,074,518		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
	TOTALS		0	1,074,518		
	L - DRUGS CHARGEABLE RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,250,199		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 11:55 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
	TOTALS		0	4,250,199		
500.00	Grand Total: Increases		782,463	7,455,999		500.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 11:55 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	165,622	14,528	0		1.00
	TOTALS		165,622	14,528			
	B - IMPLANTABLE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,684,761	0		1.00
	TOTALS		0	1,684,761			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	481,321	225,447	0		1.00
	TOTALS		481,321	225,447			
	D - DAY CARE RECLASS						
1.00	ADULT/CHILD CARE	193.01	135,520	45,466	0		1.00
	TOTALS		135,520	45,466			
	G - STD RECLASS						
1.00	INTENSIVE CARE UNIT	31.00	6,869	0	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	5,923	0	0		2.00
	TOTALS		12,792	0			
	H - EMPLOYEE WELLNESS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	51,006	0	0		1.00
	TOTALS		51,006	0			
	J - PART A RECLASS						
1.00	SUBPROVIDER - IRF	41.00	0	39,160	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	52,122	0		2.00
3.00	DIABETES CENTER	192.03	0	6,000	0		3.00
	TOTALS		0	97,282			
	K - MEDICAL SUPPLIES RECLASS						
1.00	COMMUNICATIONS	4.01	0	36	0		1.00
2.00	DATA PROCESSING	4.02	0	39	0		2.00
3.00	MATERIALS MANAGEMENT	4.03	0	157	0		3.00
4.00	ADMITTING	4.04	0	271	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	213	0		5.00
6.00	OPERATION OF PLANT	7.00	0	96	0		6.00
7.00	LAUNDRY & LINEN SERVICE	8.00	0	531	0		7.00
8.00	HOUSEKEEPING	9.00	0	3,357	0		8.00
9.00	DIETARY	10.00	0	232	0		9.00
10.00	NURSING ADMINISTRATION	13.00	0	46	0		10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00	0	58,975	0		11.00
12.00	PHARMACY	15.00	0	6,011	0		12.00
13.00	ADULTS & PEDIATRICS	30.00	0	159,162	0		13.00
14.00	INTENSIVE CARE UNIT	31.00	0	46,613	0		14.00
15.00	SUBPROVIDER - IRF	41.00	0	5,740	0		15.00
16.00	OPERATING ROOM	50.00	0	202,603	0		16.00
17.00	ANESTHESIOLOGY	53.00	0	11	0		17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	62,795	0		18.00
19.00	LABORATORY	60.00	0	168,820	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	59,780	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	15,271	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	6,642	0		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,550	0		23.00
24.00	ONCOLOGY	76.00	0	3,996	0		24.00
25.00	CARDIAC REHABILITATION	76.97	0	6,360	0		25.00
26.00	CLINIC	90.00	0	82,752	0		26.00
27.00	EMERGENCY	91.00	0	67,223	0		27.00
28.00	HOME HEALTH AGENCY	101.00	0	5,148	0		28.00
29.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	129	0		29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	108,935	0		30.00
31.00	ADULT/CHILD CARE	193.01	0	1,023	0		31.00
32.00	PARTNERSHIP HFC	194.00	0	1	0		32.00
	TOTALS		0	1,074,518			
	L - DRUGS CHARGEABLE RECLASS						
1.00	MATERIALS MANAGEMENT	4.03	0	270	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,553	0		2.00
3.00	PHARMACY	15.00	0	3,701,286	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	1,661	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	887	0		5.00
6.00	SUBPROVIDER - IRF	41.00	0	93	0		6.00
7.00	OPERATING ROOM	50.00	0	10,784	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,460	0		8.00
9.00	LABORATORY	60.00	0	2,108	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	9,444	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	22	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	30	0		12.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 11:55 am

	Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
13.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	44	0			13.00
14.00	ONCOLOGY	76.00	0	499	0			14.00
15.00	CLINIC	90.00	0	100,629	0			15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	406,429	0			16.00
	TOTALS		0	4,250,199				
500.00	Grand Total: Decreases		846,261	7,392,201				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2019 11:55 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	4,743,426	0	0	0	0	1.00
2.00	Land Improvements	2,807,066	82,220	0	82,220	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	72,464,758	6,124,333	0	6,124,333	8,964,372	4.00
5.00	Fixed Equipment	13,007,605	53,616	0	53,616	0	5.00
6.00	Movable Equipment	39,151,763	15,227,531	0	15,227,531	1,120,054	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	132,174,618	21,487,700	0	21,487,700	10,084,426	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	132,174,618	21,487,700	0	21,487,700	10,084,426	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	4,743,426	0	1.00
2.00	Land Improvements	2,889,286	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	69,624,719	0	4.00
5.00	Fixed Equipment	13,061,221	0	5.00
6.00	Movable Equipment	53,259,240	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	143,577,892	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	143,577,892	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2019 11:55 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	226,129	0	7,245	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,753,571	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,979,700	0	7,245	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	NEW CAP REL COSTS-BLDG & FIXT	0	233,374		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,753,571		2.00
3.00	Total (sum of lines 1-2)	0	4,986,945		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2019 11:55 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	53,259,240	0	53,259,240	1.000000	0	2.00
3.00	Total (sum of lines 1-2)	53,259,240	0	53,259,240	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	309,515	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,753,571	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,063,086	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-10,002	0	0	0	299,513	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,753,571	2.00
3.00	Total (sum of lines 1-2)	-10,002	0	0	0	5,053,084	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 11:55 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-17,247	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,604,186			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	0			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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 11:55 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	CAFETERIA CANTEEN VENDING REVENUE	B	-296,137	CAFETERIA	11.00	0	33.00
33.01	CAFETERIA CANTEEN VENDING REVENUE	B	-3,375	CAFETERIA	11.00	0	33.01
33.02	MISC OTHER REVENUE	B	-4,521	PATIENT ACCOUNTING	4.05	0	33.02
33.03	MISC OTHER REVENUE	B	-90,638	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISC OTHER REVENUE	B	-525	NURSING ADMINISTRATION	13.00	0	33.04
33.05	MISC OTHER REVENUE	B	-1,351	PHARMACY	15.00	0	33.05
33.06	MISC OTHER REVENUE	B	-36,523	MEDICAL RECORDS & LIBRARY	16.00	0	33.06
33.07	MISC OTHER REVENUE	B	-880	CLINIC	90.00	0	33.07
33.08	CABLE SERVICES	A	-24,422	OPERATION OF PLANT	7.00	0	33.08
33.09	TELEPHONE SERVICES	A	-1,177	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.09
33.10	TELEPHONE SERVICES	A	-18,170	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	COMMUNICATIONS	A	-15,282	COMMUNICATIONS	4.01	0	33.11
33.12	ADVERTISING EXP - A&G	A	-311,532	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	ADVERTISING EXP - WOUND CARE	A	-224	CLINIC	90.00	0	33.13
33.14	DAYCARE	B	-180,986	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	DAYCARE DISCOUNT	A	10,662	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	LOBBYING EXPENSE - IHHA	A	-1,969	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	PROF - BUILDING	A	-14,156	OPERATION OF PLANT	7.00	0	33.17
33.18	PROF - BUILDING	A	-2,970	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.19
33.20	1933 AHA LIFE	A	84,563	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.20
33.21	HAF EXPENSE	A	-3,031,664	ADMINISTRATIVE & GENERAL	5.00	0	33.21
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,562,710				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2019 11:55 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,404,808	1,404,808	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	7,683	7,683	0	0	0	2.00
3.00	60.00	LABORATORY	136,962	0	136,962	211,500	1,961	3.00
4.00	66.00	PHYSICAL THERAPY	10,842	10,842	0	0	0	4.00
5.00	68.00	SPEECH PATHOLOGY	625	625	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	124,158	59,085	65,073	211,500	325	6.00
7.00	76.00	ONCOLOGY	163,863	0	163,863	211,500	327	7.00
8.00	76.97	CARDIAC REHABILITATION	127,750	127,750	0	0	0	8.00
9.00	90.00	CLINIC	717,000	717,000	0	0	0	9.00
10.00	91.00	EMERGENCY	2,113,754	2,113,754	0	0	0	10.00
200.00			4,807,445	4,441,547	365,898		2,613	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	199,400	9,970	0	0	0	3.00
4.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	4.00
5.00	68.00	SPEECH PATHOLOGY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	33,047	1,652	0	0	0	6.00
7.00	76.00	ONCOLOGY	33,250	1,663	0	0	0	7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			265,697	13,285	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,404,808		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	7,683		2.00
3.00	60.00	LABORATORY	0	199,400	0	0		3.00
4.00	66.00	PHYSICAL THERAPY	0	0	0	10,842		4.00
5.00	68.00	SPEECH PATHOLOGY	0	0	0	625		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	33,047	32,026	91,111		6.00
7.00	76.00	ONCOLOGY	0	33,250	130,613	130,613		7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	127,750		8.00
9.00	90.00	CLINIC	0	0	0	717,000		9.00
10.00	91.00	EMERGENCY	0	0	0	2,113,754		10.00
200.00			0	265,697	162,639	4,604,186		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				NEW BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	299,513	299,513				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,753,571		4,753,571			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,405,452	3,231	2,117	9,410,800		4.00
4.01	00401	COMMUNICATIONS	310,212	426	0	28,471	339,109	4.01
4.02	00402	DATA PROCESSING	2,722,956	6,778	2,228,521	257,946	33,736	4.02
4.03	00403	MATERIALS MANAGEMENT	367,386	4,143	10,558	106,100	7,247	4.03
4.04	00404	ADMITTING	751,053	2,424	0	245,015	8,496	4.04
4.05	00405	PATIENT ACCOUNTING	1,688,828	7,200	18,634	344,934	21,991	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	2,431,916	10,315	46,772	499,526	19,242	5.00
7.00	00700	OPERATION OF PLANT	2,451,023	31,298	71,741	204,268	12,245	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	196,626	2,603	7,900	35,561	1,249	8.00
9.00	00900	HOUSEKEEPING	812,515	2,022	7,108	233,985	3,499	9.00
10.00	01000	DIETARY	385,580	4,241	33,085	86,614	6,497	10.00
11.00	01100	CAFETERIA	407,256	4,516	52,149	158,667	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,671,234	10,684	0	483,613	11,495	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	163,899	1,840	52,599	29,738	0	14.00
15.00	01500	PHARMACY	1,415,890	2,215	8,891	163,747	5,748	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	594,429	4,200	12,846	179,131	9,246	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,126,232	29,860	207,679	1,348,506	26,239	30.00
31.00	03100	INTENSIVE CARE UNIT	1,249,361	8,539	56,739	392,474	6,997	31.00
41.00	04100	SUBPROVIDER - IRF	279,209	3,051	31,267	88,214	4,498	41.00
43.00	04300	NURSERY	180,150	677	0	54,597	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,102,086	49,549	710,493	616,092	21,991	50.00
53.00	05300	ANESTHESIOLOGY	66,456	427	22,623	12,869	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,641,240	17,900	547,501	669,327	12,995	54.00
60.00	06000	LABORATORY	3,794,447	8,715	225,101	580,639	16,993	60.00
65.00	06500	RESPIRATORY THERAPY	1,070,199	405	24,681	317,860	4,498	65.00
66.00	06600	PHYSICAL THERAPY	801,464	6,863	16,098	246,236	6,247	66.00
67.00	06700	OCCUPATIONAL THERAPY	253,607	1,446	3,804	83,593	1,499	67.00
68.00	06800	SPEECH PATHOLOGY	138,724	90	596	45,722	1,499	68.00
69.00	06900	ELECTROCARDIOLOGY	316,863	1,169	54,104	91,895	10,746	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	56,336	197	2,948	16,263	500	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,262,298	0	22,365	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,684,761	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,250,199	0	0	0	0	73.00
76.00	03020	ONCOLOGY	322,728	7,578	3,448	86,649	9,246	76.00
76.97	07697	CARDIAC REHABILITATION	164,867	2,719	16,464	42,340	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,902,296	12,469	26,329	230,628	5,248	90.00
91.00	09100	EMERGENCY	2,093,151	10,756	49,567	1,076,258	14,744	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	708,725	1,413	103	207,232	5,748	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,294,738	261,959	4,574,831	9,264,710	290,379	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	78,942	1,404	7,113	16,447	3,748	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,565,728	28,071	170,761	0	40,984	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	78,817	435	866	23,938	750	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	334,287	5,232	0	82,768	1,249	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	56,802	2,412	0	7,145	1,999	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	47,905	0	0	15,792	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	77,457,219	299,513	4,753,571	9,410,800	339,109	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	Subtotal	
			4.02	4.03	4.04	4.05	4A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW 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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING	5,249,937					4.02
4.03	00403	MATERIALS MANAGEMENT	119,800	615,234				4.03
4.04	00404	ADMITTING	156,748	872	1,164,608			4.04
4.05	00405	PATIENT ACCOUNTING	338,128	1,671	0	2,421,386		4.05
5.00	00500	ADMINISTRATIVE & GENERAL	550,857	11,124	0	0	3,569,752	5.00
7.00	00700	OPERATION OF PLANT	31,350	201	0	0	2,802,126	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,153	77	0	0	264,169	8.00
9.00	00900	HOUSEKEEPING	0	626	0	0	1,059,755	9.00
10.00	01000	DIETARY	87,331	34,857	0	0	638,205	10.00
11.00	01100	CAFETERIA	0	0	0	0	622,588	11.00
13.00	01300	NURSING ADMINISTRATION	101,886	6,033	0	0	2,284,945	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,576	0	0	256,652	14.00
15.00	01500	PHARMACY	54,862	0	0	0	1,651,353	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	160,107	216	0	0	960,175	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	387,391	31,559	68,059	135,683	5,361,208	30.00
31.00	03100	INTENSIVE CARE UNIT	130,997	10,608	7,305	14,562	1,877,582	31.00
41.00	04100	SUBPROVIDER - IRF	0	1,268	3,369	6,717	417,593	41.00
43.00	04300	NURSERY	0	0	3,631	7,238	246,293	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	606,839	32,609	176,696	352,262	4,668,617	50.00
53.00	05300	ANESTHESIOLOGY	0	251	25,481	50,800	178,907	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,935	25,511	236,133	470,801	4,817,343	54.00
60.00	06000	LABORATORY	237,361	181,936	170,396	339,702	5,555,290	60.00
65.00	06500	RESPIRATORY THERAPY	124,279	14,922	30,221	60,248	1,647,313	65.00
66.00	06600	PHYSICAL THERAPY	103,006	3,061	22,101	44,060	1,249,136	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,914	0	9,150	18,241	389,254	67.00
68.00	06800	SPEECH PATHOLOGY	17,914	0	2,419	4,822	211,786	68.00
69.00	06900	ELECTROCARDIOLOGY	219,447	0	25,917	51,669	771,810	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	231	554	1,104	78,133	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	65,046	48,906	97,498	3,496,113	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	26,869	53,565	1,765,195	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	75,020	149,560	4,474,779	73.00
76.00	03020	ONCOLOGY	64,938	2,074	4,167	8,307	509,135	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,741	3,147	6,274	237,552	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	161,226	56,515	57,333	114,299	2,566,343	90.00
91.00	09100	EMERGENCY	267,591	21,014	161,767	322,499	4,017,347	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	54,862	901	5,967	11,896	996,847	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,210,922	513,500	1,164,608	2,321,807	59,643,296	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	88,451	2,467	0	0	198,572	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	890,104	92,891	0	99,579	16,888,118	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	11,196	10	0	0	116,012	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	22,393	6,139	0	0	452,068	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	26,871	227	0	0	95,456	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	63,697	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,249,937	615,234	1,164,608	2,421,386	77,457,219	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW 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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL	3,569,752					5.00
7.00	00700	OPERATION OF PLANT	135,379	2,937,505				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,763	32,719	309,651			8.00
9.00	00900	HOUSEKEEPING	51,200	25,410	60,037	1,196,402		9.00
10.00	01000	DIETARY	30,834	53,311	6,531	22,151	751,032	10.00
11.00	01100	CAFETERIA	30,079	56,768	0	23,587	0	11.00
13.00	01300	NURSING ADMINISTRATION	110,393	134,291	0	55,799	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,400	23,124	0	9,608	0	14.00
15.00	01500	PHARMACY	79,782	27,846	0	11,570	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,389	52,794	0	21,936	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	259,016	375,325	71,524	155,950	641,759	30.00
31.00	03100	INTENSIVE CARE UNIT	90,712	107,329	17,864	44,596	57,354	31.00
41.00	04100	SUBPROVIDER - IRF	20,175	38,353	13,633	15,936	51,919	41.00
43.00	04300	NURSERY	11,899	8,506	0	3,534	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	225,555	622,810	56,335	258,784	0	50.00
53.00	05300	ANESTHESIOLOGY	8,644	5,362	0	2,228	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	232,740	225,002	25,931	93,490	0	54.00
60.00	06000	LABORATORY	268,393	109,548	0	45,518	0	60.00
65.00	06500	RESPIRATORY THERAPY	79,587	5,090	0	2,115	0	65.00
66.00	06600	PHYSICAL THERAPY	60,350	86,261	1,832	35,842	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,806	18,169	0	7,550	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,232	1,130	0	469	0	68.00
69.00	06900	ELECTROCARDIOLOGY	37,288	14,699	2,433	6,107	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,775	2,477	0	1,029	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	168,908	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	85,282	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	216,190	0	0	0	0	73.00
76.00	03020	ONCOLOGY	24,598	95,257	0	39,580	0	76.00
76.97	07697	CARDIAC REHABILITATION	11,477	34,175	0	14,200	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	123,988	156,734	1,853	65,124	0	90.00
91.00	09100	EMERGENCY	194,090	135,203	47,061	56,178	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	48,161	17,761	0	7,380	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,709,085	2,465,454	305,034	1,000,261	751,032	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,594	17,652	0	7,335	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	815,938	352,841	4,617	146,608	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	5,605	5,471	0	2,273	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	21,841	65,764	0	27,325	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	4,612	30,323	0	12,600	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	3,077	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
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)	3,569,752	2,937,505	309,651	1,196,402	751,032	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW 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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	733,022					11.00
13.00	01300	NURSING ADMINISTRATION	20,872	2,606,300				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,323	43,016	349,123			14.00
15.00	01500	PHARMACY	13,312	0	0	1,783,863		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,231	0	0	0	1,101,525	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	99,236	987,483	0	0	61,346	30.00
31.00	03100	INTENSIVE CARE UNIT	32,002	318,453	0	0	6,396	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	3,192	41.00
43.00	04300	NURSERY	3,647	36,294	0	0	3,441	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,045	557,698	0	0	167,424	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	24,154	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,401	0	0	0	223,704	54.00
60.00	06000	LABORATORY	61,284	0	0	0	161,517	60.00
65.00	06500	RESPIRATORY THERAPY	25,865	0	0	0	28,646	65.00
66.00	06600	PHYSICAL THERAPY	19,508	0	0	0	20,949	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,625	0	0	0	8,673	67.00
68.00	06800	SPEECH PATHOLOGY	3,101	0	0	0	2,293	68.00
69.00	06900	ELECTROCARDIOLOGY	9,799	0	0	0	22,233	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,437	0	0	0	525	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	349,123	0	50,377	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	25,469	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,783,863	73,204	73.00
76.00	03020	ONCOLOGY	7,602	0	0	0	3,950	76.00
76.97	07697	CARDIAC REHABILITATION	3,619	0	0	0	2,983	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	34,843	0	0	0	54,345	90.00
91.00	09100	EMERGENCY	66,663	663,356	0	0	151,048	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	14,620	0	0	0	5,656	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	557,035	2,606,300	349,123	1,783,863	1,101,525	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,180	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	140,647	0	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	1,722	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	16,233	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	233	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	13,972	0	0	0	0	194.04
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)	733,022	2,606,300	349,123	1,783,863	1,101,525	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW 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
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	DATA PROCESSING					4.02
4.03	00403	MATERIALS MANAGEMENT					4.03
4.04	00404	ADMITTING					4.04
4.05	00405	PATIENT ACCOUNTING					4.05
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	8,012,847	0	8,012,847		30.00
31.00	03100	INTENSIVE CARE UNIT	2,552,288	0	2,552,288		31.00
41.00	04100	SUBPROVIDER - IRF	560,801	0	560,801		41.00
43.00	04300	NURSERY	313,614	0	313,614		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,613,268	0	6,613,268		50.00
53.00	05300	ANESTHESIOLOGY	219,295	0	219,295		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,671,611	0	5,671,611		54.00
60.00	06000	LABORATORY	6,201,550	0	6,201,550		60.00
65.00	06500	RESPIRATORY THERAPY	1,788,616	0	1,788,616		65.00
66.00	06600	PHYSICAL THERAPY	1,473,878	0	1,473,878		66.00
67.00	06700	OCCUPATIONAL THERAPY	448,077	0	448,077		67.00
68.00	06800	SPEECH PATHOLOGY	229,011	0	229,011		68.00
69.00	06900	ELECTROCARDIOLOGY	864,369	0	864,369		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	87,376	0	87,376		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,064,521	0	4,064,521		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,875,946	0	1,875,946		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,548,036	0	6,548,036		73.00
76.00	03020	ONCOLOGY	680,122	0	680,122		76.00
76.97	07697	CARDIAC REHABILITATION	304,006	0	304,006		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3,003,230	0	3,003,230		90.00
91.00	09100	EMERGENCY	5,330,946	0	5,330,946		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,090,425	0	1,090,425		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,933,833	0	57,933,833		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	236,333	0	236,333		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,348,769	0	18,348,769		192.00
192.01	19201	SOUTH CLINIC	0	0	0		192.01
192.02	19202	WEST CLINIC	0	0	0		192.02
192.03	19203	DIABETES CENTER	131,083	0	131,083		192.03
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	583,231	0	583,231		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0		193.03
194.00	07950	PARTNERSHIP HFC	143,224	0	143,224		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0		194.02
194.03	07953	JAIL	66,774	0	66,774		194.03
194.04	07954	ATHLETIC TRAINERS	13,972	0	13,972		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	77,457,219	0	77,457,219		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,231	2,117	5,348	5,348	4.00
4.01	00401	COMMUNICATIONS	0	426	0	426	16	4.01
4.02	00402	DATA PROCESSING	0	6,778	2,228,521	2,235,299	146	4.02
4.03	00403	MATERIALS MANAGEMENT	0	4,143	10,558	14,701	60	4.03
4.04	00404	ADMITTING	0	2,424	0	2,424	139	4.04
4.05	00405	PATIENT ACCOUNTING	0	7,200	18,634	25,834	196	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	0	10,315	46,772	57,087	283	5.00
7.00	00700	OPERATION OF PLANT	0	31,298	71,741	103,039	116	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,603	7,900	10,503	20	8.00
9.00	00900	HOUSEKEEPING	0	2,022	7,108	9,130	133	9.00
10.00	01000	DIETARY	0	4,241	33,085	37,326	49	10.00
11.00	01100	CAFETERIA	0	4,516	52,149	56,665	90	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,684	0	10,684	274	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,840	52,599	54,439	17	14.00
15.00	01500	PHARMACY	0	2,215	8,891	11,106	93	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,200	12,846	17,046	102	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	29,860	207,679	237,539	775	30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,539	56,739	65,278	223	31.00
41.00	04100	SUBPROVIDER - IRF	0	3,051	31,267	34,318	50	41.00
43.00	04300	NURSERY	0	677	0	677	31	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	49,549	710,493	760,042	349	50.00
53.00	05300	ANESTHESIOLOGY	0	427	22,623	23,050	7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,900	547,501	565,401	380	54.00
60.00	06000	LABORATORY	0	8,715	225,101	233,816	329	60.00
65.00	06500	RESPIRATORY THERAPY	0	405	24,681	25,086	180	65.00
66.00	06600	PHYSICAL THERAPY	0	6,863	16,098	22,961	140	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,446	3,804	5,250	47	67.00
68.00	06800	SPEECH PATHOLOGY	0	90	596	686	26	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,169	54,104	55,273	52	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	197	2,948	3,145	9	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	22,365	22,365	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	7,578	3,448	11,026	49	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,719	16,464	19,183	24	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	12,469	26,329	38,798	131	90.00
91.00	09100	EMERGENCY	0	10,756	49,567	60,323	611	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,413	103	1,516	118	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	261,959	4,574,831	4,836,790	5,265	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,404	7,113	8,517	9	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	28,071	170,761	198,832	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	435	866	1,301	14	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	5,232	0	5,232	47	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	2,412	0	2,412	4	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	9	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
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	299,513	4,753,571	5,053,084	5,348	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	COMMUNICATIONS	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	
			4.01	4.02	4.03	4.04	4.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW 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
4.01	00401	COMMUNICATIONS	442					4.01
4.02	00402	DATA PROCESSING	44	2,235,489				4.02
4.03	00403	MATERIALS MANAGEMENT	9	51,012	65,782			4.03
4.04	00404	ADMITTING	11	66,745	93	69,412		4.04
4.05	00405	PATIENT ACCOUNTING	29	143,979	179	0	170,217	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	25	234,562	1,189	0	0	5.00
7.00	00700	OPERATION OF PLANT	16	13,349	21	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2	8,582	8	0	0	8.00
9.00	00900	HOUSEKEEPING	5	0	67	0	0	9.00
10.00	01000	DIETARY	8	37,187	3,727	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	15	43,384	645	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	917	0	0	14.00
15.00	01500	PHARMACY	7	23,361	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12	68,176	23	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34	164,956	3,374	4,058	9,538	30.00
31.00	03100	INTENSIVE CARE UNIT	9	55,780	1,134	436	1,024	31.00
41.00	04100	SUBPROVIDER - IRF	6	0	136	201	472	41.00
43.00	04300	NURSERY	0	0	0	217	509	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29	258,399	3,487	10,537	24,763	50.00
53.00	05300	ANESTHESIOLOGY	0	0	27	1,519	3,571	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17	83,432	2,728	14,046	33,098	54.00
60.00	06000	LABORATORY	22	101,071	19,455	10,161	23,880	60.00
65.00	06500	RESPIRATORY THERAPY	6	52,919	1,595	1,802	4,235	65.00
66.00	06600	PHYSICAL THERAPY	8	43,861	327	1,318	3,097	66.00
67.00	06700	OCCUPATIONAL THERAPY	2	7,628	0	546	1,282	67.00
68.00	06800	SPEECH PATHOLOGY	2	7,628	0	144	339	68.00
69.00	06900	ELECTROCARDIOLOGY	14	93,443	0	1,545	3,632	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1	0	25	33	78	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	6,955	2,916	6,854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,602	3,765	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,474	10,514	73.00
76.00	03020	ONCOLOGY	12	27,652	222	248	584	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	186	188	441	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7	68,652	6,042	3,419	8,035	90.00
91.00	09100	EMERGENCY	19	113,944	2,247	9,646	22,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	7	23,361	96	356	836	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	378	1,793,063	54,905	69,412	163,217	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5	37,663	264	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	53	379,018	9,932	0	7,000	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	1	4,768	1	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	2	9,535	656	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	3	11,442	24	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
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)	442	2,235,489	65,782	69,412	170,217	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW 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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL	293,146					5.00
7.00	00700	OPERATION OF PLANT	11,116	127,657				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,048	1,422	21,585			8.00
9.00	00900	HOUSEKEEPING	4,204	1,104	4,185	18,828		9.00
10.00	01000	DIETARY	2,532	2,317	455	349	83,950	10.00
11.00	01100	CAFETERIA	2,470	2,467	0	371	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,064	5,836	0	878	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,018	1,005	0	151	0	14.00
15.00	01500	PHARMACY	6,551	1,210	0	182	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,809	2,294	0	345	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,268	16,311	4,986	2,454	71,736	30.00
31.00	03100	INTENSIVE CARE UNIT	7,448	4,664	1,245	702	6,411	31.00
41.00	04100	SUBPROVIDER - IRF	1,657	1,667	950	251	5,803	41.00
43.00	04300	NURSERY	977	370	0	56	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,520	27,063	3,927	4,075	0	50.00
53.00	05300	ANESTHESIOLOGY	710	233	0	35	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,110	9,778	1,808	1,471	0	54.00
60.00	06000	LABORATORY	22,038	4,761	0	716	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,535	221	0	33	0	65.00
66.00	06600	PHYSICAL THERAPY	4,955	3,749	128	564	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,544	790	0	119	0	67.00
68.00	06800	SPEECH PATHOLOGY	840	49	0	7	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,062	639	170	96	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	310	108	0	16	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,869	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,003	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,751	0	0	0	0	73.00
76.00	03020	ONCOLOGY	2,020	4,140	0	623	0	76.00
76.97	07697	CARDIAC REHABILITATION	942	1,485	0	223	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,181	6,811	129	1,025	0	90.00
91.00	09100	EMERGENCY	15,937	5,876	3,280	884	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,954	772	0	116	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	222,443	107,142	21,263	15,742	83,950	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	788	767	0	115	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	67,030	15,334	322	2,307	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	460	238	0	36	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	1,793	2,858	0	430	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	379	1,318	0	198	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	253	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
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)	293,146	127,657	21,585	18,828	83,950	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW 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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	62,063					11.00
13.00	01300	NURSING ADMINISTRATION	1,767	72,547				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	366	1,197	59,110			14.00
15.00	01500	PHARMACY	1,127	0	0	43,637		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,713	0	0	0	93,520	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,402	27,487	0	0	5,211	30.00
31.00	03100	INTENSIVE CARE UNIT	2,710	8,864	0	0	543	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	271	41.00
43.00	04300	NURSERY	309	1,010	0	0	292	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,745	15,524	0	0	14,221	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,052	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,521	0	0	0	18,960	54.00
60.00	06000	LABORATORY	5,189	0	0	0	13,719	60.00
65.00	06500	RESPIRATORY THERAPY	2,190	0	0	0	2,433	65.00
66.00	06600	PHYSICAL THERAPY	1,652	0	0	0	1,779	66.00
67.00	06700	OCCUPATIONAL THERAPY	476	0	0	0	737	67.00
68.00	06800	SPEECH PATHOLOGY	263	0	0	0	195	68.00
69.00	06900	ELECTROCARDIOLOGY	830	0	0	0	1,888	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	122	0	0	0	45	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	59,110	0	4,279	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,163	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	43,637	6,218	73.00
76.00	03020	ONCOLOGY	644	0	0	0	335	76.00
76.97	07697	CARDIAC REHABILITATION	306	0	0	0	253	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,950	0	0	0	4,616	90.00
91.00	09100	EMERGENCY	5,644	18,465	0	0	12,830	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,238	0	0	0	480	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,164	72,547	59,110	43,637	93,520	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	269	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,907	0	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	146	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	1,374	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	20	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	1,183	0	0	0	0	194.04
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)	62,063	72,547	59,110	43,637	93,520	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW 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
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	DATA PROCESSING					4.02
4.03	00403	MATERIALS MANAGEMENT					4.03
4.04	00404	ADMITTING					4.04
4.05	00405	PATIENT ACCOUNTING					4.05
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	578,129	0	578,129		30.00
31.00	03100	INTENSIVE CARE UNIT	156,471	0	156,471		31.00
41.00	04100	SUBPROVIDER - IRF	45,782	0	45,782		41.00
43.00	04300	NURSERY	4,448	0	4,448		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,145,681	0	1,145,681		50.00
53.00	05300	ANESTHESIOLOGY	31,204	0	31,204		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	754,750	0	754,750		54.00
60.00	06000	LABORATORY	435,157	0	435,157		60.00
65.00	06500	RESPIRATORY THERAPY	97,235	0	97,235		65.00
66.00	06600	PHYSICAL THERAPY	84,539	0	84,539		66.00
67.00	06700	OCCUPATIONAL THERAPY	18,421	0	18,421		67.00
68.00	06800	SPEECH PATHOLOGY	10,179	0	10,179		68.00
69.00	06900	ELECTROCARDIOLOGY	160,644	0	160,644		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,892	0	3,892		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,348	0	116,348		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,533	0	14,533		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,594	0	82,594		73.00
76.00	03020	ONCOLOGY	47,555	0	47,555		76.00
76.97	07697	CARDIAC REHABILITATION	23,231	0	23,231		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	150,796	0	150,796		90.00
91.00	09100	EMERGENCY	272,376	0	272,376		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	32,850	0	32,850		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,266,815	0	4,266,815		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	48,397	0	48,397		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	691,735	0	691,735		192.00
192.01	19201	SOUTH CLINIC	0	0	0		192.01
192.02	19202	WEST CLINIC	0	0	0		192.02
192.03	19203	DIABETES CENTER	6,965	0	6,965		192.03
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	21,927	0	21,927		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0		193.03
194.00	07950	PARTNERSHIP HFC	15,800	0	15,800		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0		194.02
194.03	07953	JAIL	262	0	262		194.03
194.04	07954	ATHLETIC TRAINERS	1,183	0	1,183		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	5,053,084	0	5,053,084		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (TOTAL FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	
			1.00	2.00	4.00	4.01	4.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	276,616					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,575,452				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,984	1,147	28,547,892			4.00
4.01	00401	COMMUNICATIONS	393	0	86,368	1,357		4.01
4.02	00402	DATA PROCESSING	6,260	1,207,398	782,484	135	4,689	4.02
4.03	00403	MATERIALS MANAGEMENT	3,826	5,720	321,857	29	107	4.03
4.04	00404	ADMITTING	2,239	0	743,258	34	140	4.04
4.05	00405	PATIENT ACCOUNTING	6,650	10,096	1,046,364	88	302	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	9,526	25,341	1,515,323	77	492	5.00
7.00	00700	OPERATION OF PLANT	28,905	38,869	619,650	49	28	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,404	4,280	107,874	5	18	8.00
9.00	00900	HOUSEKEEPING	1,867	3,851	709,799	14	0	9.00
10.00	01000	DIETARY	3,917	17,925	262,744	26	78	10.00
11.00	01100	CAFETERIA	4,171	28,254	481,321	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,867	0	1,467,049	46	91	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,699	28,498	90,212	0	0	14.00
15.00	01500	PHARMACY	2,046	4,817	496,731	23	49	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,879	6,960	543,399	37	143	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,577	112,519	4,090,755	105	346	30.00
31.00	03100	INTENSIVE CARE UNIT	7,886	30,741	1,190,578	28	117	31.00
41.00	04100	SUBPROVIDER - IRF	2,818	16,940	267,599	18	0	41.00
43.00	04300	NURSERY	625	0	165,622	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,761	384,940	1,868,927	88	542	50.00
53.00	05300	ANESTHESIOLOGY	394	12,257	39,039	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,532	296,632	2,030,417	52	175	54.00
60.00	06000	LABORATORY	8,049	121,958	1,761,381	68	212	60.00
65.00	06500	RESPIRATORY THERAPY	374	13,372	964,235	18	111	65.00
66.00	06600	PHYSICAL THERAPY	6,338	8,722	746,962	25	92	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,335	2,061	253,582	6	16	67.00
68.00	06800	SPEECH PATHOLOGY	83	323	138,700	6	16	68.00
69.00	06900	ELECTROCARDIOLOGY	1,080	29,313	278,766	43	196	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182	1,597	49,335	2	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,117	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	6,999	1,868	262,852	37	58	76.00
76.97	07697	CARDIAC REHABILITATION	2,511	8,920	128,438	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,516	14,265	699,614	21	144	90.00
91.00	09100	EMERGENCY	9,934	26,855	3,264,850	59	239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,305	56	628,642	23	49	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	241,932	2,478,612	28,104,727	1,162	3,761	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,297	3,854	49,892	15	79	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,925	92,517	0	164	795	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	402	469	72,615	3	10	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	4,832	0	251,077	5	20	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	2,228	0	21,676	8	24	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	47,905	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
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)	299,513	4,753,571	9,410,800	339,109	5,249,937	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.082775	1.845723	0.329650	249.896094	1,119.628279	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (TOTAL FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	
			1.00	2.00	4.00	4.01	4.02	
204.00		Cost to be allocated (per Wkst. B, Part II)			5,348	442	2,235,489	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000187	0.325718	476.751759	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: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			4.03	4.04	4.05	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW 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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT	4,250,172					4.03
4.04	00404	ADMITTING	6,021	219,070,050				4.04
4.05	00405	PATIENT ACCOUNTING	11,547	0	228,466,065			4.05
5.00	00500	ADMINISTRATIVE & GENERAL	76,847	0	0	-3,569,752	73,887,467	5.00
7.00	00700	OPERATION OF PLANT	1,389	0	0	0	2,802,126	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	531	0	0	0	264,169	8.00
9.00	00900	HOUSEKEEPING	4,327	0	0	0	1,059,755	9.00
10.00	01000	DIETARY	240,799	0	0	0	638,205	10.00
11.00	01100	CAFETERIA	0	0	0	0	622,588	11.00
13.00	01300	NURSING ADMINISTRATION	41,680	0	0	0	2,284,945	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	59,248	0	0	0	256,652	14.00
15.00	01500	PHARMACY	0	0	0	0	1,651,353	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,491	0	0	0	960,175	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	218,014	12,802,731	12,802,731	0	5,361,208	30.00
31.00	03100	INTENSIVE CARE UNIT	73,284	1,374,067	1,374,067	0	1,877,582	31.00
41.00	04100	SUBPROVIDER - IRF	8,757	633,782	633,782	0	417,593	41.00
43.00	04300	NURSERY	0	682,972	682,972	0	246,293	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	225,270	33,238,564	33,238,564	0	4,668,617	50.00
53.00	05300	ANESTHESIOLOGY	1,731	4,793,345	4,793,345	0	178,907	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	176,234	44,413,753	44,413,753	0	4,817,343	54.00
60.00	06000	LABORATORY	1,256,853	32,053,440	32,053,440	0	5,555,290	60.00
65.00	06500	RESPIRATORY THERAPY	103,087	5,684,820	5,684,820	0	1,647,313	65.00
66.00	06600	PHYSICAL THERAPY	21,145	4,157,385	4,157,385	0	1,249,136	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,721,165	1,721,165	0	389,254	67.00
68.00	06800	SPEECH PATHOLOGY	0	455,033	455,033	0	211,786	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,875,348	4,875,348	0	771,810	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,598	104,166	104,166	0	78,133	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	449,350	9,199,698	9,199,698	0	3,496,113	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,054,283	5,054,283	0	1,765,195	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,112,110	14,112,110	0	4,474,779	73.00
76.00	03020	ONCOLOGY	14,331	783,813	783,813	0	509,135	76.00
76.97	07697	CARDIAC REHABILITATION	12,025	592,042	592,042	0	237,552	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	390,415	10,784,955	10,784,955	0	2,566,343	90.00
91.00	09100	EMERGENCY	145,170	30,430,139	30,430,139	0	4,017,347	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,226	1,122,439	1,122,439	0	996,847	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,547,370	219,070,050	219,070,050	-3,569,752	56,073,544	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,042	0	0	0	198,572	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	641,714	0	9,396,015	0	16,888,118	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	67	0	0	0	116,012	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	42,409	0	0	0	452,068	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	1,570	0	0	0	95,456	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	63,697	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
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)	615,234	1,164,608	2,421,386		3,569,752	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.144755	0.005316	0.010598		0.048313	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	65,782	69,412	170,217		293,146	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			4.03	4.04	4.05	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.015477	0.000317	0.000745		0.003967	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: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW 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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	215,833					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,404	382,791				8.00
9.00	00900	HOUSEKEEPING	1,867	74,218	211,562			9.00
10.00	01000	DIETARY	3,917	8,074	3,917	19,485		10.00
11.00	01100	CAFETERIA	4,171	0	4,171	0	848,522	11.00
13.00	01300	NURSING ADMINISTRATION	9,867	0	9,867	0	24,161	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,699	0	1,699	0	5,004	14.00
15.00	01500	PHARMACY	2,046	0	2,046	0	15,409	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,879	0	3,879	0	23,419	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,577	88,418	27,577	16,650	114,872	30.00
31.00	03100	INTENSIVE CARE UNIT	7,886	22,083	7,886	1,488	37,045	31.00
41.00	04100	SUBPROVIDER - IRF	2,818	16,853	2,818	1,347	0	41.00
43.00	04300	NURSERY	625	0	625	0	4,222	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,761	69,641	45,761	0	64,876	50.00
53.00	05300	ANESTHESIOLOGY	394	0	394	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,532	32,056	16,532	0	61,815	54.00
60.00	06000	LABORATORY	8,049	0	8,049	0	70,940	60.00
65.00	06500	RESPIRATORY THERAPY	374	0	374	0	29,940	65.00
66.00	06600	PHYSICAL THERAPY	6,338	2,265	6,338	0	22,582	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,335	0	1,335	0	6,511	67.00
68.00	06800	SPEECH PATHOLOGY	83	0	83	0	3,590	68.00
69.00	06900	ELECTROCARDIOLOGY	1,080	3,008	1,080	0	11,343	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182	0	182	0	1,663	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	6,999	0	6,999	0	8,800	76.00
76.97	07697	CARDIAC REHABILITATION	2,511	0	2,511	0	4,189	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,516	2,291	11,516	0	40,333	90.00
91.00	09100	EMERGENCY	9,934	58,177	9,934	0	77,167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,305	0	1,305	0	16,924	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	181,149	377,084	176,878	19,485	644,805	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,297	0	1,297	0	3,681	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,925	5,707	25,925	0	162,808	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	402	0	402	0	1,993	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	4,832	0	4,832	0	18,791	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	2,228	0	2,228	0	270	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	16,174	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,937,505	309,651	1,196,402	751,032	733,022	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.610083	0.808930	5.655089	38.544111	0.863881	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	127,657	21,585	18,828	83,950	62,063	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	
			7.00	8.00	9.00	10.00	11.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.591462	0.056388	0.088995	4.308442	0.073142	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: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW 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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	303,186					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,004	100				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	218,614,547		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	114,872	0	0	12,174,206		30.00
31.00	03100	INTENSIVE CARE UNIT	37,045	0	0	1,269,232		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	633,411		41.00
43.00	04300	NURSERY	4,222	0	0	682,972		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	64,876	0	0	33,225,583		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,793,345		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	44,409,502		54.00
60.00	06000	LABORATORY	0	0	0	32,053,440		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,684,820		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,157,385		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,721,165		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	455,033		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,412,092		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	104,166		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100	0	9,997,382		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	5,054,283		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	14,527,510		73.00
76.00	03020	ONCOLOGY	0	0	0	783,813		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	592,042		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	10,784,955		90.00
91.00	09100	EMERGENCY	77,167	0	0	29,975,771		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,122,439		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	303,186	100	100	218,614,547		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	SOUTH CLINIC	0	0	0	0		192.01
192.02	19202	WEST CLINIC	0	0	0	0		192.02
192.03	19203	DIABETES CENTER	0	0	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0		193.03
194.00	07950	PARTNERSHIP HFC	0	0	0	0		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0	0		194.02
194.03	07953	JAIL	0	0	0	0		194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,606,300	349,123	1,783,863	1,101,525		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.596373	3,491.230000	17,838.630000	0.005039		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	72,547	59,110	43,637	93,520		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 11:55 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.239282	591.100000	436.370000	0.000428		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: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | 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	8,012,847		8,012,847	0	8,012,847	30.00
31.00	03100	INTENSIVE CARE UNIT	2,552,288		2,552,288	0	2,552,288	31.00
41.00	04100	SUBPROVIDER - IRF	560,801		560,801	0	560,801	41.00
43.00	04300	NURSERY	313,614		313,614	0	313,614	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,613,268		6,613,268	0	6,613,268	50.00
53.00	05300	ANESTHESIOLOGY	219,295		219,295	0	219,295	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,671,611		5,671,611	0	5,671,611	54.00
60.00	06000	LABORATORY	6,201,550		6,201,550	0	6,201,550	60.00
65.00	06500	RESPIRATORY THERAPY	1,788,616	0	1,788,616	0	1,788,616	65.00
66.00	06600	PHYSICAL THERAPY	1,473,878	0	1,473,878	0	1,473,878	66.00
67.00	06700	OCCUPATIONAL THERAPY	448,077	0	448,077	0	448,077	67.00
68.00	06800	SPEECH PATHOLOGY	229,011	0	229,011	0	229,011	68.00
69.00	06900	ELECTROCARDIOLOGY	864,369		864,369	32,026	896,395	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	87,376		87,376	0	87,376	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,064,521		4,064,521	0	4,064,521	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,875,946		1,875,946	0	1,875,946	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,548,036		6,548,036	0	6,548,036	73.00
76.00	03020	ONCOLOGY	680,122		680,122	130,613	810,735	76.00
76.97	07697	CARDIAC REHABILITATION	304,006		304,006	0	304,006	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,003,230		3,003,230	0	3,003,230	90.00
91.00	09100	EMERGENCY	5,330,946		5,330,946	0	5,330,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	322,826		322,826		322,826	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,090,425		1,090,425		1,090,425	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	58,256,659	0	58,256,659	162,639	58,419,298	200.00
201.00		Less Observation Beds	322,826		322,826		322,826	201.00
202.00		Total (see instructions)	57,933,833	0	57,933,833	162,639	58,096,472	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | 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	10,872,336		10,872,336			30.00
31.00	03100	INTENSIVE CARE UNIT	1,269,232		1,269,232			31.00
41.00	04100	SUBPROVIDER - IRF	633,411		633,411			41.00
43.00	04300	NURSERY	682,972		682,972			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,935,364	27,290,219	33,225,583	0.199041	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	625,703	4,167,642	4,793,345	0.045750	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,570,984	38,838,518	44,409,502	0.127712	0.000000	54.00
60.00	06000	LABORATORY	6,761,588	25,291,852	32,053,440	0.193475	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,875,967	2,808,853	5,684,820	0.314630	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	725,211	3,432,174	4,157,385	0.354520	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	704,876	1,016,289	1,721,165	0.260334	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	165,077	289,956	455,033	0.503284	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,035,079	3,377,013	4,412,092	0.195909	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	31,544	72,622	104,166	0.838815	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,149,651	6,847,731	9,997,382	0.406559	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,652,343	3,401,940	5,054,283	0.371160	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,288,285	10,239,225	14,527,510	0.450734	0.000000	73.00
76.00	03020	ONCOLOGY	2,714	781,099	783,813	0.867710	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	266	591,776	592,042	0.513487	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,866	10,775,089	10,784,955	0.278465	0.000000	90.00
91.00	09100	EMERGENCY	3,489,686	26,486,085	29,975,771	0.177842	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,301,870	1,301,870	0.247971	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,122,439	1,122,439			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	50,482,155	168,132,392	218,614,547			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	50,482,155	168,132,392	218,614,547			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | 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
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.199041	50.00
53.00	05300	ANESTHESIOLOGY	0.045750	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127712	54.00
60.00	06000	LABORATORY	0.193475	60.00
65.00	06500	RESPIRATORY THERAPY	0.314630	65.00
66.00	06600	PHYSICAL THERAPY	0.354520	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.260334	67.00
68.00	06800	SPEECH PATHOLOGY	0.503284	68.00
69.00	06900	ELECTROCARDIOLOGY	0.203168	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.838815	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.406559	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.371160	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.450734	73.00
76.00	03020	ONCOLOGY	1.034347	76.00
76.97	07697	CARDIAC REHABILITATION	0.513487	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.278465	90.00
91.00	09100	EMERGENCY	0.177842	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.247971	92.00
		OTHER REIMBURSABLE COST CENTERS		
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: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 11:55 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,012,847		8,012,847	0	8,012,847	30.00
31.00	03100	INTENSIVE CARE UNIT	2,552,288		2,552,288	0	2,552,288	31.00
41.00	04100	SUBPROVIDER - IRF	560,801		560,801	0	560,801	41.00
43.00	04300	NURSERY	313,614		313,614	0	313,614	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,613,268		6,613,268	0	6,613,268	50.00
53.00	05300	ANESTHESIOLOGY	219,295		219,295	0	219,295	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,671,611		5,671,611	0	5,671,611	54.00
60.00	06000	LABORATORY	6,201,550		6,201,550	0	6,201,550	60.00
65.00	06500	RESPIRATORY THERAPY	1,788,616	0	1,788,616	0	1,788,616	65.00
66.00	06600	PHYSICAL THERAPY	1,473,878	0	1,473,878	0	1,473,878	66.00
67.00	06700	OCCUPATIONAL THERAPY	448,077	0	448,077	0	448,077	67.00
68.00	06800	SPEECH PATHOLOGY	229,011	0	229,011	0	229,011	68.00
69.00	06900	ELECTROCARDIOLOGY	864,369		864,369	32,026	896,395	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	87,376		87,376	0	87,376	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,064,521		4,064,521	0	4,064,521	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,875,946		1,875,946	0	1,875,946	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,548,036		6,548,036	0	6,548,036	73.00
76.00	03020	ONCOLOGY	680,122		680,122	130,613	810,735	76.00
76.97	07697	CARDIAC REHABILITATION	304,006		304,006	0	304,006	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,003,230		3,003,230	0	3,003,230	90.00
91.00	09100	EMERGENCY	5,330,946		5,330,946	0	5,330,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	322,826		322,826		322,826	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,090,425		1,090,425		1,090,425	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	58,256,659	0	58,256,659	162,639	58,419,298	200.00
201.00		Less Observation Beds	322,826		322,826		322,826	201.00
202.00		Total (see instructions)	57,933,833	0	57,933,833	162,639	58,096,472	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 11:55 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,872,336		10,872,336			30.00
31.00	03100	INTENSIVE CARE UNIT	1,269,232		1,269,232			31.00
41.00	04100	SUBPROVIDER - IRF	633,411		633,411			41.00
43.00	04300	NURSERY	682,972		682,972			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,935,364	27,290,219	33,225,583	0.199041	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	625,703	4,167,642	4,793,345	0.045750	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,570,984	38,838,518	44,409,502	0.127712	0.000000	54.00
60.00	06000	LABORATORY	6,761,588	25,291,852	32,053,440	0.193475	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,875,967	2,808,853	5,684,820	0.314630	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	725,211	3,432,174	4,157,385	0.354520	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	704,876	1,016,289	1,721,165	0.260334	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	165,077	289,956	455,033	0.503284	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,035,079	3,377,013	4,412,092	0.195909	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	31,544	72,622	104,166	0.838815	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,149,651	6,847,731	9,997,382	0.406559	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,652,343	3,401,940	5,054,283	0.371160	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,288,285	10,239,225	14,527,510	0.450734	0.000000	73.00
76.00	03020	ONCOLOGY	2,714	781,099	783,813	0.867710	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	266	591,776	592,042	0.513487	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,866	10,775,089	10,784,955	0.278465	0.000000	90.00
91.00	09100	EMERGENCY	3,489,686	26,486,085	29,975,771	0.177842	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,301,870	1,301,870	0.247971	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,122,439	1,122,439			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	50,482,155	168,132,392	218,614,547			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	50,482,155	168,132,392	218,614,547			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 11:55 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	ONCOLOGY	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	578,129	0	578,129	5,684	101.71	30.00
31.00	INTENSIVE CARE UNIT	156,471		156,471	496	315.47	31.00
41.00	SUBPROVIDER - IRF	45,782	0	45,782	449	101.96	41.00
43.00	NURSERY	4,448		4,448	731	6.08	43.00
200.00	Total (lines 30 through 199)	784,830		784,830	7,360		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	2,298	233,730		30.00
31.00	INTENSIVE CARE UNIT	208	65,618		31.00
41.00	SUBPROVIDER - IRF	118	12,031		41.00
43.00	NURSERY	0	0		43.00
200.00	Total (lines 30 through 199)	2,624	311,379		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,145,681	33,225,583	0.034482	1,888,091	65,105	50.00
53.00	05300	ANESTHESIOLOGY	31,204	4,793,345	0.006510	226,750	1,476	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	754,750	44,409,502	0.016995	2,258,438	38,382	54.00
60.00	06000	LABORATORY	435,157	32,053,440	0.013576	3,116,455	42,309	60.00
65.00	06500	RESPIRATORY THERAPY	97,235	5,684,820	0.017104	1,060,059	18,131	65.00
66.00	06600	PHYSICAL THERAPY	84,539	4,157,385	0.020335	267,172	5,433	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,421	1,721,165	0.010703	249,080	2,666	67.00
68.00	06800	SPEECH PATHOLOGY	10,179	455,033	0.022370	62,001	1,387	68.00
69.00	06900	ELECTROCARDIOLOGY	160,644	4,412,092	0.036410	866,784	31,560	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,892	104,166	0.037363	11,496	430	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,348	9,997,382	0.011638	1,143,207	13,305	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,533	5,054,283	0.002875	758,805	2,182	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,594	14,527,510	0.005685	1,880,974	10,693	73.00
76.00	03020	ONCOLOGY	47,555	783,813	0.060671	556	34	76.00
76.97	07697	CARDIAC REHABILITATION	23,231	592,042	0.039239	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	150,796	10,784,955	0.013982	9,866	138	90.00
91.00	09100	EMERGENCY	272,376	29,975,771	0.009087	1,595,320	14,497	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	23,292	1,301,870	0.017891	0	0	92.00
200.00		Total (lines 50 through 199)	3,472,427	204,034,157		15,395,054	247,728	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	5,684	0.00	2,298	30.00
31.00	03100	INTENSIVE CARE UNIT		0	496	0.00	208	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	449	0.00	118	41.00
43.00	04300	NURSERY		0	731	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	7,360		2,624	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
41.00	04100	SUBPROVIDER - IRF	0	41.00
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: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	33,225,583	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,793,345	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	44,409,502	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	32,053,440	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,684,820	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,157,385	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,721,165	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	455,033	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,412,092	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	104,166	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,997,382	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	5,054,283	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,527,510	0.000000	73.00
76.00	03020	ONCOLOGY	0	0	0	783,813	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	592,042	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	10,784,955	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	29,975,771	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,301,870	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	204,034,157		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | 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	1,888,091	0	5,616,022	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	226,750	0	601,134	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,258,438	0	9,085,880	0	54.00
60.00	06000	LABORATORY	0.000000	3,116,455	0	2,302,136	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,060,059	0	617,617	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	267,172	0	15,098	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	249,080	0	13,471	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	62,001	0	1,423	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	866,784	0	988,807	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	11,496	0	17,342	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,143,207	0	1,066,481	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	758,805	0	678,168	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,880,974	0	4,809,946	0	73.00
76.00	03020	ONCOLOGY	0.000000	556	0	126,743	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	91,953	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	9,866	0	2,423,926	0	90.00
91.00	09100	EMERGENCY	0.000000	1,595,320	0	4,597,761	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	486,691	0	92.00
200.00		Total (lines 50 through 199)		15,395,054	0	33,540,599	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.199041	5,616,022	0	0	1,117,819	50.00
53.00	05300	ANESTHESIOLOGY	0.045750	601,134	0	0	27,502	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127712	9,085,880	0	0	1,160,376	54.00
60.00	06000	LABORATORY	0.193475	2,302,136	0	0	445,406	60.00
65.00	06500	RESPIRATORY THERAPY	0.314630	617,617	0	0	194,321	65.00
66.00	06600	PHYSICAL THERAPY	0.354520	15,098	0	0	5,353	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.260334	13,471	0	0	3,507	67.00
68.00	06800	SPEECH PATHOLOGY	0.503284	1,423	0	0	716	68.00
69.00	06900	ELECTROCARDIOLOGY	0.195909	988,807	0	0	193,716	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.838815	17,342	0	0	14,547	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.406559	1,066,481	0	0	433,587	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.371160	678,168	0	0	251,709	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.450734	4,809,946	0	20	2,168,006	73.00
76.00	03020	ONCOLOGY	0.867710	126,743	0	0	109,976	76.00
76.97	07697	CARDIAC REHABILITATION	0.513487	91,953	0	0	47,217	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.278465	2,423,926	3,968	0	674,979	90.00
91.00	09100	EMERGENCY	0.177842	4,597,761	0	0	817,675	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.247971	486,691	0	0	120,685	92.00
200.00		Subtotal (see instructions)		33,540,599	3,968	20	7,787,097	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		33,540,599	3,968	20	7,787,097	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9	73.00
76.00	03020	ONCOLOGY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1,105	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	1,105	9	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	1,105	9	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Subprovider - IRF | 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	1,145,681	33,225,583	0.034482	1,848	64	50.00
53.00	05300	ANESTHESIOLOGY	31,204	4,793,345	0.006510	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	754,750	44,409,502	0.016995	14,458	246	54.00
60.00	06000	LABORATORY	435,157	32,053,440	0.013576	56,909	773	60.00
65.00	06500	RESPIRATORY THERAPY	97,235	5,684,820	0.017104	6,432	110	65.00
66.00	06600	PHYSICAL THERAPY	84,539	4,157,385	0.020335	59,628	1,213	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,421	1,721,165	0.010703	60,861	651	67.00
68.00	06800	SPEECH PATHOLOGY	10,179	455,033	0.022370	16,598	371	68.00
69.00	06900	ELECTROCARDIOLOGY	160,644	4,412,092	0.036410	7,863	286	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,892	104,166	0.037363	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,348	9,997,382	0.011638	1,461	17	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,533	5,054,283	0.002875	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,594	14,527,510	0.005685	11,052	63	73.00
76.00	03020	ONCOLOGY	47,555	783,813	0.060671	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	23,231	592,042	0.039239	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	150,796	10,784,955	0.013982	0	0	90.00
91.00	09100	EMERGENCY	272,376	29,975,771	0.009087	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,301,870	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	3,449,135	204,034,157		237,110	3,794	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001
Component CCN: 15-T001
Period: From 01/01/2018 To 12/31/2018
Worksheet D Part IV
Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	33,225,583	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,793,345	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	44,409,502	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	32,053,440	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,684,820	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,157,385	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,721,165	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	455,033	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,412,092	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	104,166	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,997,382	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	5,054,283	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,527,510	0.000000	73.00
76.00	03020	ONCOLOGY	0	0	0	783,813	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	592,042	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	10,784,955	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	29,975,771	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,301,870	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	204,034,157		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Subprovider - IRF | 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	1,848	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	14,458	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	56,909	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,432	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	59,628	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	60,861	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	16,598	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,863	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,461	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	11,052	0	0	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		237,110	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | 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)	5,684	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,684	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)	5,455	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,298	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,012,847	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,012,847	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)	8,012,847	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,409.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,239,537	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)	3,239,537	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,552,288	496	5,145.74	208	1,070,314	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)	3,868,881	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,178,732	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)	299,348	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	247,728	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	547,076	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,631,656	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)	229	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,409.72	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	322,826	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | 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	578,129	8,012,847	0.072150	322,826	23,292	90.00
91.00	Nursing School cost	0	8,012,847	0.000000	322,826	0	91.00
92.00	Allied health cost	0	8,012,847	0.000000	322,826	0	92.00
93.00	All other Medical Education	0	8,012,847	0.000000	322,826	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 11:55 am
	Title XVIII	Subprovider - IRF	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)	449	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	449	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)	449	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	118	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	560,801	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	560,801	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)	560,801	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,249.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	147,382	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)	147,382	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Subprovider - IRF | 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)	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)	67,759	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	215,141	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)	12,031	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,794	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	15,825	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	199,316	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Subprovider - IRF | 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	45,782	560,801	0.081637	0	0	90.00
91.00	Nursing School cost	0	560,801	0.000000	0	0	91.00
92.00	Allied health cost	0	560,801	0.000000	0	0	92.00
93.00	All other Medical Education	0	560,801	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 11:55 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,684	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,684	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)	5,455	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	55	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)	731	15.00
16.00	Nursery days (title V or XIX only)	7	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,012,847	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,012,847	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)	8,012,847	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,409.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	77,535	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	77,535	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 11:55 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	313,614	731	429.02	7	3,003	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,552,288	496	5,145.74	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)	44,950	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	125,488	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	229	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,409.72	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	322,826	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 11:55 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	578,129	8,012,847	0.072150	322,826	23,292	90.00
91.00	Nursing School cost	0	8,012,847	0.000000	322,826	0	91.00
92.00	Allied health cost	0	8,012,847	0.000000	322,826	0	92.00
93.00	All other Medical Education	0	8,012,847	0.000000	322,826	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 11:55 am
	Title XIX	Subprovider - IRF	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)	449	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	449	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)	449	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	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)	731	15.00
16.00	Nursery days (title V or XIX only)	7	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	560,801	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	560,801	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)	560,801	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,249.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 11:55 am

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 11:55 am

Title XIX | Subprovider - IRF | 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	45,782	560,801	0.081637	0	0	90.00
91.00	Nursing School cost	0	560,801	0.000000	0	0	91.00
92.00	Allied health cost	0	560,801	0.000000	0	0	92.00
93.00	All other Medical Education	0	560,801	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,815,347		30.00
31.00	03100	INTENSIVE CARE UNIT		478,358		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.199041	1,888,091	375,808	50.00
53.00	05300	ANESTHESIOLOGY	0.045750	226,750	10,374	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127712	2,258,438	288,430	54.00
60.00	06000	LABORATORY	0.193475	3,116,455	602,956	60.00
65.00	06500	RESPIRATORY THERAPY	0.314630	1,060,059	333,526	65.00
66.00	06600	PHYSICAL THERAPY	0.354520	267,172	94,718	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.260334	249,080	64,844	67.00
68.00	06800	SPEECH PATHOLOGY	0.503284	62,001	31,204	68.00
69.00	06900	ELECTROCARDIOLOGY	0.203168	866,784	176,103	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.838815	11,496	9,643	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.406559	1,143,207	464,781	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.371160	758,805	281,638	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.450734	1,880,974	847,819	73.00
76.00	03020	ONCOLOGY	1.034347	556	575	76.00
76.97	07697	CARDIAC REHABILITATION	0.513487	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.278465	9,866	2,747	90.00
91.00	09100	EMERGENCY	0.177842	1,595,320	283,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.247971	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		15,395,054	3,868,881	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)		15,395,054		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Subprovider - IRF | 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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		158,549		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.199041	1,848	368	50.00
53.00	05300	ANESTHESIOLOGY	0.045750	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127712	14,458	1,846	54.00
60.00	06000	LABORATORY	0.193475	56,909	11,010	60.00
65.00	06500	RESPIRATORY THERAPY	0.314630	6,432	2,024	65.00
66.00	06600	PHYSICAL THERAPY	0.354520	59,628	21,139	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.260334	60,861	15,844	67.00
68.00	06800	SPEECH PATHOLOGY	0.503284	16,598	8,354	68.00
69.00	06900	ELECTROCARDIOLOGY	0.203168	7,863	1,598	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.838815	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.406559	1,461	594	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.371160	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.450734	11,052	4,982	73.00
76.00	03020	ONCOLOGY	1.034347	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.513487	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.278465	0	0	90.00
91.00	09100	EMERGENCY	0.177842	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.247971	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		237,110	67,759	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)		237,110		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 11:55 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		143,093		30.00
31.00	03100	INTENSIVE CARE UNIT		2,733		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.199041	73,795	14,688	50.00
53.00	05300	ANESTHESIOLOGY	0.045750	10,001	458	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127712	16,520	2,110	54.00
60.00	06000	LABORATORY	0.193475	36,767	7,113	60.00
65.00	06500	RESPIRATORY THERAPY	0.314630	7,015	2,207	65.00
66.00	06600	PHYSICAL THERAPY	0.354520	613	217	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.260334	509	133	67.00
68.00	06800	SPEECH PATHOLOGY	0.503284	128	64	68.00
69.00	06900	ELECTROCARDIOLOGY	0.195909	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.838815	44	37	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.406559	9,064	3,685	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.371160	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.450734	25,151	11,336	73.00
76.00	03020	ONCOLOGY	0.867710	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.513487	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.278465	0	0	90.00
91.00	09100	EMERGENCY	0.177842	16,319	2,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.247971	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		195,926	44,950	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)		195,926		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 11:55 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,383,023	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	21,216	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	82.25	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.27	30.00
31.00	Percentage of Medicaid patient days (see instructions)	20.88	31.00
32.00	Sum of lines 30 and 31	23.15	32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.32	33.00
34.00	Disproportionate share adjustment (see instructions)	111,967	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	605,548	815,209	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	452,917	205,478	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	658,395		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	6,174,601		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	6,174,601	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	440,075	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	6,614,676	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	6,614,676	61.00
62.00	Deductibles billed to program beneficiaries	735,516	62.00
63.00	Coinsurance billed to program beneficiaries	2,680	63.00
64.00	Allowable bad debts (see instructions)	95,909	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	62,341	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	95,909	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	5,938,821	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	34,414	70.93
70.94	HRR adjustment amount (see instructions)	-1,831	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 11:55 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2018	46,667	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,018,071	71.00
71.01	Sequestration adjustment (see instructions)		120,361	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		5,751,245	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		146,465	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		89,375	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,383,023	0		5,383,023	5,383,023	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	21,216	0	0	21,216	21,216	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0832	0.0832	0.0832	0.0832		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	111,967	0	0	111,967	111,967	11.00
11.01	Uncompensated care payments	36.00	658,395	0	452,917	205,478	658,395	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,174,601	0	452,917	5,721,684	6,174,601	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,174,601	0	452,917	5,721,684	6,174,601	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	440,075	0	0	440,075	440,075	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	452,917	6,161,759	6,614,676	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	438,364	0	0	438,364	438,364	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,711	0	0	1,711	1,711	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	440,075	0	0	440,075	440,075	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.103036	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			46,667		46,667	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,383,023		5,383,023	5,383,023	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	21,216	0	21,216	21,216	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0832	0.0832	0.0832		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	111,967	0	111,967	111,967	11.00
11.01	Uncompensated care payments	36.00	658,395	452,917	205,478	658,395	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,174,601	452,917	5,721,684	6,174,601	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,174,601	452,917	5,721,684	6,174,601	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	440,075	0	440,075	440,075	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			452,917	6,161,759	6,614,676	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	438,364	0	438,364	438,364	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,711	0	1,711	1,711	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	440,075	0	440,075	440,075	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	34,414	0	34,414	34,414	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-1,831	0	-1,831	-1,831	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 11:55 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,114	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,787,097	2.00
3.00	OPPS payments	5,900,484	3.00
4.00	Outlier payment (see instructions)	37,739	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)	1,114	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	3,988	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)	3,988	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)	3,988	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,874	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)	1,114	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)	5,938,223	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,198,831	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)	4,740,506	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)	4,740,506	30.00
31.00	Primary payer payments	277	31.00
32.00	Subtotal (line 30 minus line 31)	4,740,229	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)	79,626	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	51,757	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	79,626	36.00
37.00	Subtotal (see instructions)	4,791,986	37.00
38.00	MSP-LCC reconciliation amount from PS&R	90	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)	4,791,896	40.00
40.01	Sequestration adjustment (see instructions)	95,838	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	4,754,045	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-57,987	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,728,959		4,644,245	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	12/31/2018	22,286	12/31/2018	81,700	3.01
3.02			0	04/05/2018	28,100	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)		22,286		109,800	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,751,245		4,754,045	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		146,465		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		57,987	6.02
7.00	Total Medicare program liability (see instructions)		5,897,710		4,696,058	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: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		196,092		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		196,092		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		4,459		0	6.02
7.00	Total Medicare program liability (see instructions)		191,633		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: 15-0001	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/29/2019 11:55 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part III Date/Time Prepared: 5/29/2019 11:55 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	187,896	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	5,411	3.00
4.00	Outlier Payments	6,233	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	1.230137	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	199,540	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	199,540	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	199,540	19.00
20.00	Deductibles	3,996	20.00
21.00	Subtotal (line 19 minus line 20)	195,544	21.00
22.00	Coinsurance	0	22.00
23.00	Subtotal (line 21 minus line 22)	195,544	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	195,544	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	195,544	32.00
32.01	Sequestration adjustment (see instructions)	3,911	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	196,092	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-4,459	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	6,233	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-3 Part VII Date/Time Prepared: 5/29/2019 11:55 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	125,488		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	125,488	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	125,488	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	145,826		8.00
9.00	Ancillary service charges	195,926	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	341,752	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	341,752	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	216,264	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	125,488	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	125,488	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	125,488	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	125,488	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	125,488	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	125,488	0	40.00
41.00	Interim payments	189,044	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-63,556	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/29/2019 11:55 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	39,451,645	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,948,915	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,174,485	0	0	0	7.00
8.00	Prepaid expenses	2,153,107	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)	56,728,152	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	4,743,426	0	0	0	12.00
13.00	Land improvements	2,889,286	0	0	0	13.00
14.00	Accumulated depreciation	-1,293,077	0	0	0	14.00
15.00	Buildings	69,624,719	0	0	0	15.00
16.00	Accumulated depreciation	-28,197,145	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	13,061,221	0	0	0	19.00
20.00	Accumulated depreciation	-11,144,034	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	76,492,114	0	0	0	23.00
24.00	Accumulated depreciation	-35,274,274	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)	90,902,236	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	52,769,227	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	52,769,227	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	200,399,615	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,020,473	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,894,229	0	0	0	38.00
39.00	Payroll taxes payable	894,185	0	0	0	39.00
40.00	Notes and loans payable (short term)	16,802,043	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	694,009	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	28,304,939	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	171,042	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	171,042	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,475,981	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	171,923,634				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)	171,923,634	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	200,399,615	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/29/2019 11:55 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		167,262,942		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,660,692				2.00
3.00	Total (sum of line 1 and line 2)		171,923,634		0		3.00
4.00	Additions (credit adjustments) (specify)	0		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)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		171,923,634		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		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)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		171,923,634		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			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: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2019 11:55 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	12,183,833		12,183,833	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	633,782		633,782	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,817,615		12,817,615	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,374,067		1,374,067	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)	1,374,067		1,374,067	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,191,682		14,191,682	17.00
18.00	Ancillary services	32,798,489	128,440,474	161,238,963	18.00
19.00	Outpatient services	3,609,434	37,859,938	41,469,372	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		1,122,439	1,122,439	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NRCC	-309	9,487,376	9,487,067	27.00
27.01	PRO FEES	840,702	3,721,831	4,562,533	27.01
27.02	OTHER INCOME	4,433	5,317	9,750	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	51,444,431	180,637,375	232,081,806	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		86,019,929		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)		86,019,929		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/29/2019 11:55 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	232,081,806	1.00
2.00	Less contractual allowances and discounts on patients' accounts	158,823,524	2.00
3.00	Net patient revenues (line 1 minus line 2)	73,258,282	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	86,019,929	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-12,761,647	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	OTHER INCOME	911,338	24.00
24.01	NON-OPERATING INCOME	614,581	24.01
24.02	UPL INCOME	15,894,942	24.02
24.03	RECONCILING ITEM	1,478	24.03
25.00	Total other income (sum of lines 6-24)	17,422,339	25.00
26.00	Total (line 5 plus line 25)	4,660,692	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)	4,660,692	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H | Date/Time Prepared: 5/29/2019 11:55 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	179,151	0	38,622	0	41,674	259,447	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	213,705	0	0	0	0	213,705	6.00
7.00	Physical Therapy	120,102	0	0	0	0	120,102	7.00
8.00	Occupational Therapy	84,320	0	0	0	0	84,320	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	100	0	0	0	0	100	10.00
11.00	Home Health Aide	31,264	0	0	0	0	31,264	11.00
12.00	Supplies (see instructions)	0	0	0	0	4,935	4,935	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	628,642	0	38,622	0	46,609	713,873	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-5,148	254,299	0	254,299			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	213,705	0	213,705			6.00
7.00	Physical Therapy	0	120,102	0	120,102			7.00
8.00	Occupational Therapy	0	84,320	0	84,320			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	100	0	100			10.00
11.00	Home Health Aide	0	31,264	0	31,264			11.00
12.00	Supplies (see instructions)	0	4,935	0	4,935			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-5,148	708,725	0	708,725			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-1 Part I | Date/Time Prepared: 5/29/2019 11:55 am

Home Health Agency I | PPS

			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	254,299	0	0	0	0	254,299	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	213,705	0	0	0	0	213,705	6.00
7.00	Physical Therapy	120,102	0	0	0	0	120,102	7.00
8.00	Occupational Therapy	84,320	0	0	0	0	84,320	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	100	0	0	0	0	100	10.00
11.00	Home Health Aide	31,264	0	0	0	0	31,264	11.00
12.00	Supplies (see instructions)	4,935	0	0	0	0	4,935	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	708,725	0	0	0	0	708,725	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	254,299			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	119,590	333,295		6.00
7.00	Physical Therapy	67,210	187,312		7.00
8.00	Occupational Therapy	47,186	131,506		8.00
9.00	Speech Pathology	0	0		9.00
10.00	Medical Social Services	56	156		10.00
11.00	Home Health Aide	17,495	48,759		11.00
12.00	Supplies (see instructions)	2,762	7,697		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		708,725		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-1 Part II | Date/Time Prepared: 5/29/2019 11:55 am

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-254,299	454,426	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	213,705	6.00
7.00	Physical Therapy	0	0	0	0	0	120,102	7.00
8.00	Occupational Therapy	0	0	0	0	0	84,320	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	100	10.00
11.00	Home Health Aide	0	0	0	0	0	31,264	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	4,935	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-254,299	454,426	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		254,299	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.559605	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 HHA CCN: 15-7510

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

Worksheet H-2 Part I Date/Time Prepared: 5/29/2019 11:55 am

Home Health Agency I

PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	DATA PROCESSING	
		0	1.00	2.00	4.00	4.01	4.02	
1.00	Administrative and General	0	1,413	103	207,232	5,748	54,862	1.00
2.00	Skilled Nursing Care	333,295	0	0	0	0	0	2.00
3.00	Physical Therapy	187,312	0	0	0	0	0	3.00
4.00	Occupational Therapy	131,506	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	156	0	0	0	0	0	6.00
7.00	Home Health Aide	48,759	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	7,697	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	708,725	1,413	103	207,232	5,748	54,862	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		4.03	4.04	4.05	4A.05	5.00	7.00	
1.00	Administrative and General	901	5,967	11,896	288,122	13,920	17,761	1.00
2.00	Skilled Nursing Care	0	0	0	333,295	16,102	0	2.00
3.00	Physical Therapy	0	0	0	187,312	9,050	0	3.00
4.00	Occupational Therapy	0	0	0	131,506	6,353	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	156	8	0	6.00
7.00	Home Health Aide	0	0	0	48,759	2,356	0	7.00
8.00	Supplies (see instructions)	0	0	0	7,697	372	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	901	5,967	11,896	996,847	48,161	17,761	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-2 Part I | Date/Time Prepared: 5/29/2019 11:55 am

Home Health Agency I | PPS

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	7,380	0	14,620	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	7,380	0	14,620	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		15.00	16.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	5,656	347,459	0	347,459		1.00
2.00	Skilled Nursing Care	0	0	349,397	0	349,397	163,399	2.00
3.00	Physical Therapy	0	0	196,362	0	196,362	91,832	3.00
4.00	Occupational Therapy	0	0	137,859	0	137,859	64,472	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	164	0	164	77	6.00
7.00	Home Health Aide	0	0	51,115	0	51,115	23,905	7.00
8.00	Supplies (see instructions)	0	0	8,069	0	8,069	3,774	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	5,656	1,090,425	0	1,090,425	347,459	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.467665	21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001
HHA CCN: 15-7510

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

Worksheet H-2
Part I
Date/Time Prepared:
5/29/2019 11:55 am

Home Health Agency I

PPS

	Cost Center Description	Total HHA Costs				
		28.00				
1.00	Administrative and General					1.00
2.00	Skilled Nursing Care	512,796				2.00
3.00	Physical Therapy	288,194				3.00
4.00	Occupational Therapy	202,331				4.00
5.00	Speech Pathology	0				5.00
6.00	Medical Social Services	241				6.00
7.00	Home Health Aide	75,020				7.00
8.00	Supplies (see instructions)	11,843				8.00
9.00	Drugs	0				9.00
10.00	DME	0				10.00
11.00	Home Dialysis Aide Services	0				11.00
12.00	Respiratory Therapy	0				12.00
13.00	Private Duty Nursing	0				13.00
14.00	Clinic	0				14.00
15.00	Health Promotion Activities	0				15.00
16.00	Day Care Program	0				16.00
17.00	Home Delivered Meals Program	0				17.00
18.00	Homemaker Service	0				18.00
19.00	All Others (specify)	0				19.00
19.50	Telemedicine	0				19.50
20.00	Total (sum of lines 1-19) (2)	1,090,425				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0001
HHA CCN: 15-7510

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

Worksheet H-2 Part II
Date/Time Prepared: 5/29/2019 11:55 am

Home Health Agency I

PPS

	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	MATERIALS MANAGEMENT (SUPPLY USAGE)	
		NEW BLDG & FIXT (TOTAL FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00	4.00	4.01	4.02	4.03	
1.00	Administrative and General	1,305	56	628,642	23	49	6,226	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,305	56	628,642	23	49	6,226	20.00
21.00	Total cost to be allocated	1,413	103	207,232	5,748	54,862	901	21.00
22.00	Unit cost multiplier	1.082759	1.839286	0.329650	249.913043	1,119.632653	0.144716	22.00

	Cost Center Description	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		4.04	4.05	5A	5.00	7.00	8.00	
1.00	Administrative and General	1,122,439	1,122,439	0	288,122	1,305	0	1.00
2.00	Skilled Nursing Care	0	0	0	333,295	0	0	2.00
3.00	Physical Therapy	0	0	0	187,312	0	0	3.00
4.00	Occupational Therapy	0	0	0	131,506	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	156	0	0	6.00
7.00	Home Health Aide	0	0	0	48,759	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	7,697	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,122,439	1,122,439		996,847	1,305	0	20.00
21.00	Total cost to be allocated	5,967	11,896		48,161	17,761	0	21.00
22.00	Unit cost multiplier	0.005316	0.010598		0.048313	13.609962	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0001 HHA CCN: 15-7510

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

Worksheet H-2 Part II Date/Time Prepared: 5/29/2019 11:55 am

Home Health Agency I

PPS

	Cost Center Description	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	1,305	0	16,924	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,305	0	16,924	0	0	0	20.00
21.00	Total cost to be allocated	7,380	0	14,620	0	0	0	21.00
22.00	Unit cost multiplier	5.655172	0.000000	0.863862	0.000000	0.000000	0.000000	22.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
1.00	Administrative and General	1,122,439	1.00
2.00	Skilled Nursing Care	0	2.00
3.00	Physical Therapy	0	3.00
4.00	Occupational Therapy	0	4.00
5.00	Speech Pathology	0	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	0	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
19.50	Telemedicine	0	19.50
20.00	Total (sum of lines 1-19)	1,122,439	20.00
21.00	Total cost to be allocated	5,656	21.00
22.00	Unit cost multiplier	0.005039	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part I | Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	512,796		512,796	2,527	202.93	1.00
2.00	Physical Therapy	3.00	288,194	0	288,194	1,801	160.02	2.00
3.00	Occupational Therapy	4.00	202,331	0	202,331	1,169	173.08	3.00
4.00	Speech Pathology	5.00	0	0	0	49	0.00	4.00
5.00	Medical Social Services	6.00	241		241	1	241.00	5.00
6.00	Home Health Aide	7.00	75,020		75,020	2	37,510.00	6.00
7.00	Total (sum of lines 1-6)		1,078,582	0	1,078,582	5,549		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		18020	0	27			8.00
8.01	Skilled Nursing Care		26900	0	1,037			8.01
9.00	Physical Therapy		18020	0	34			9.00
9.01	Physical Therapy		26900	0	849			9.01
10.00	Occupational Therapy		18020	0	22			10.00
10.01	Occupational Therapy		26900	0	537			10.01
11.00	Speech Pathology		18020	0	1			11.00
11.01	Speech Pathology		26900	0	23			11.01
12.00	Medical Social Services		18020	0	0			12.00
12.01	Medical Social Services		26900	0	0			12.01
13.00	Home Health Aide		18020	0	0			13.00
13.01	Home Health Aide		26900	0	2			13.01
14.00	Total (sum of lines 8-13)			0	2,532			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	11,843	0	11,843	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,064		0	215,918		1.00
2.00	Physical Therapy	0	883		0	141,298		2.00
3.00	Occupational Therapy	0	559		0	96,752		3.00
4.00	Speech Pathology	0	24		0	0		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	2		0	75,020		6.00
7.00	Total (sum of lines 1-6)	0	2,532		0	528,988		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part I | Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	3,369	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	215,918						1.00
2.00	Physical Therapy	141,298						2.00
3.00	Occupational Therapy	96,752						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	75,020						6.00
7.00	Total (sum of lines 1-6)	528,988						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0001
HHA CCN: 15-7510

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

Worksheet H-3
Part II
Date/Time Prepared:
5/29/2019 11:55 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.354520	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.260334	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.503284	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.406559	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.450734	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/29/2019 11:55 am

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	478,357	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	2,033	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	480,390	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	480,390	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	480,390	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	480,390	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	480,390	31.00
31.01	Sequestration adjustment (see instructions)	0	9,608	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	470,782	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-5 | Date/Time Prepared: 5/29/2019 11:55 am

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		470,782	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		470,782	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		470,782	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0001	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/29/2019 11:55 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	438,364	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,711	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	16.44	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	440,075	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00