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: 15-0157	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/26/2018 2:56 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/26/2018 Time: 2:56 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT CARMEL HOSPITAL (15-0157) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 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	574,851	66,992	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	574,851	66,992	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 10:58 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 13500 NORTH MERIDIAN STREET	PO Box:			1.00
2.00	City: CARMEL	State: IN	Zip Code: 46033	County: HAMILTON	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	ST. VINCENT CARMEL HOSPITAL	150157	26900	1	01/14/2004	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	1		21.00
	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	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	460	25	0	13	2,465	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 10:58 am

		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)	N		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) or (ii)? 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) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	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

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

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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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

		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 10:58 am

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

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	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: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 10:58 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.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	622,961	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046	140.00

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	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: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 250 WEST 96TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46260	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)	10/01/2016	12/31/2016	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: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/26/2018 10:58 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.	Y	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/10/2018	Y	10/10/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

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		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?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JOHN	KUHN	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3236	JOHN.KUHN@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0157	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/26/2018 10:58 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.	REIMBURSEMENT 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: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 11/26/2018 10:58 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	128	46,720	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)		128	46,720	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,650	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	NEONATAL INTENSIVE CARE UNIT	35.00	15	5,475	0.00	0	12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		153	55,845	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		153				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

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	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,235	185	13,240			1.00
2.00	HMO and other (see instructions)	1,346	2,478				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,235	185	13,240			7.00
8.00	INTENSIVE CARE UNIT	345	49	794			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	NEONATAL INTENSIVE CARE UNIT	0	234	2,024			12.00
13.00	NURSERY		17	2,892			13.00
14.00	Total (see instructions)	4,580	485	18,950	0.00	519.95	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	519.95	27.00
28.00	Observation Bed Days		0	2,210			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			852			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	868			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

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	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,224	94	6,899	1.00
2.00	HMO and other (see instructions)			369	695		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,224	94	6,899	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 11/26/2018 10:58 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	40,257,570	262,222	40,519,792	1,081,762.38	37.46	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		370,965	0	370,965	1,832.77	202.41	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		3,388,247	0	3,388,247	24,571.01	137.90	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		2,990,333	0	2,990,333	77,865.73	38.40	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,641,756	0	1,641,756	54,375.78	30.19	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		255,355	0	255,355	2,252.94	113.34	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		1,504,292	0	1,504,292	33,405.62	45.03	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		7,693,215	0	7,693,215	175,043.50	43.95	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)		9,433,418	0	9,433,418			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		334,093	0	334,093			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		99,276	0	99,276			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		906,746	0	906,746			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		2,184,079	0	2,184,079			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	-199,574	262,222	62,648	2,620.34	23.91	26.00
27.00	Administrative & General	5.00	4,800,612	0	4,800,612	101,788.02	47.16	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II | Date/Time Prepared: 11/26/2018 10:58 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.)		6,938,933	0	6,938,933	116,561.30	59.53	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	252,905	0	252,905	11,387.10	22.21	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,306,819	0	1,306,819	54,198.79	24.11	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		567,907	0	567,907	22,238.37	25.54	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,250,381	0	1,250,381	29,621.95	42.21	38.00
39.00	Central Services and Supply	14.00	325,517	0	325,517	14,837.93	21.94	39.00
40.00	Pharmacy	15.00	2,058,999	0	2,058,999	45,544.86	45.21	40.00
41.00	Medical Records & Medical Records Library	16.00	14,825	0	14,825	382.42	38.77	41.00
42.00	Social Service	17.00	153,223	0	153,223	4,383.16	34.96	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part III Date/Time Prepared: 11/26/2018 10:58 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)		42,692,649	262,222	42,954,871	1,172,324.10	36.64	1.00
2.00	Excluded area salaries (see instructions)		1,641,756	0	1,641,756	54,375.78	30.19	2.00
3.00	Subtotal salaries (line 1 minus line 2)		41,050,893	262,222	41,313,115	1,117,948.32	36.95	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,452,862	0	9,452,862	210,702.06	44.86	4.00
5.00	Subtotal wage-related costs (see inst.)		11,716,773	0	11,716,773	0.00	28.36	5.00
6.00	Total (sum of lines 3 thru 5)		62,220,528	262,222	62,482,750	1,328,650.38	47.03	6.00
7.00	Total overhead cost (see instructions)		17,470,547	262,222	17,732,769	403,564.24	43.94	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part IV Date/Time Prepared: 11/26/2018 10:58 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,658,641	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)	348,469	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	279,596	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)	3,876,270	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,318,042	9.00
10.00	Dental, Hearing and Vision Plan	23,259	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	9,834	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-5,179	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	248,096	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	63,807	14.00
15.00	'Workers' Compensation Insurance	181,839	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	98	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,666,440	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	27,137	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	55,853	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	21,331	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,773,533	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part V Date/Time Prepared: 11/26/2018 10:58 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	255,355	10,773,533	1.00
2.00	Hospital	255,355	10,773,533	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/26/2018 10:58 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)	0.205257	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,931,968	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	60,311,178	6.00
7.00	Medicaid cost (line 1 times line 6)	12,379,291	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)	9,447,323	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)	9,447,323	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)	6,569,631	6,091,237	12,660,868	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,348,463	6,091,237	7,439,700	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)	1,348,463	6,091,237	7,439,700	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)	3,540,068	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	122,825	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	188,962	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,351,106	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	753,975	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	8,193,675	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	17,640,998	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/26/2018 10:58 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		8,785,105	8,785,105	-8,993	8,776,112	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,987,769	3,987,769	0	3,987,769	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-199,574	10,452,259	10,252,685	0	10,252,685	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,800,612	40,475,932	45,276,544	8,993	45,285,537	5.00
7.00	00700	OPERATION OF PLANT	252,905	4,489,489	4,742,394	0	4,742,394	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	663,087	663,087	0	663,087	8.00
9.00	00900	HOUSEKEEPING	0	1,636,402	1,636,402	0	1,636,402	9.00
10.00	01000	DIETARY	0	1,941,669	1,941,669	-1,087,873	853,796	10.00
11.00	01100	CAFETERIA	0	0	0	1,087,873	1,087,873	11.00
13.00	01300	NURSING ADMINISTRATION	1,250,381	274,206	1,524,587	0	1,524,587	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	325,517	64,833	390,350	0	390,350	14.00
15.00	01500	PHARMACY	2,058,999	614,075	2,673,074	0	2,673,074	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,825	1,068	15,893	0	15,893	16.00
17.00	01700	SOCIAL SERVICE	153,223	106,113	259,336	0	259,336	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,207,332	2,714,162	12,921,494	-1,111,764	11,809,730	30.00
31.00	03100	INTENSIVE CARE UNIT	977,143	635,180	1,612,323	0	1,612,323	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,270,674	581,669	2,852,343	0	2,852,343	35.00
43.00	04300	NURSERY	0	0	0	1,111,764	1,111,764	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,935,529	5,762,731	9,698,260	0	9,698,260	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,127,930	1,340,434	3,468,364	0	3,468,364	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,725,208	955,906	2,681,114	0	2,681,114	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	250,069	25,546	275,615	0	275,615	54.02
57.00	05700	CT SCAN	541,446	202,054	743,500	0	743,500	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	357,565	287,070	644,635	0	644,635	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	3,235,973	3,235,973	0	3,235,973	60.00
65.00	06500	RESPIRATORY THERAPY	924,214	175,363	1,099,577	0	1,099,577	65.00
66.00	06600	PHYSICAL THERAPY	462,920	51,195	514,115	0	514,115	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,082	5,032	20,114	0	20,114	68.00
69.00	06900	ELECTROCARDIOLOGY	97,559	22,295	119,854	0	119,854	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	73,457	14,336	87,793	0	87,793	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,934,176	4,934,176	0	4,934,176	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,037,833	6,037,833	0	6,037,833	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,098,821	3,098,821	0	3,098,821	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,691,038	7,039,203	9,730,241	0	9,730,241	75.00
76.00	03330	ENDOSCOPY	1,562,968	1,450,977	3,013,945	0	3,013,945	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,738,792	612,813	2,351,605	0	2,351,605	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,615,814	112,674,776	151,290,590	0	151,290,590	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	115,481	366,271	481,752	0	481,752	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	354,989	68,687	423,676	0	423,676	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	551,929	39,662	591,591	0	591,591	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	619,357	199,407	818,764	0	818,764	194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	40,257,570	113,348,803	153,606,373	0	153,606,373	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/26/2018 10:58 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,439,674	7,336,438		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	14,312	4,002,081		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	24,410	10,277,095		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-19,687,625	25,597,912		5.00
7.00	00700	OPERATION OF PLANT	-70,693	4,671,701		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	663,087		8.00
9.00	00900	HOUSEKEEPING	0	1,636,402		9.00
10.00	01000	DIETARY	-52,304	801,492		10.00
11.00	01100	CAFETERIA	-447,147	640,726		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,524,587		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	390,350		14.00
15.00	01500	PHARMACY	-3,425	2,669,649		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,893		16.00
17.00	01700	SOCIAL SERVICE	-14,192	245,144		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,270,094	9,539,636		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,612,323		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-1,017,455	1,834,888		35.00
43.00	04300	NURSERY	0	1,111,764		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-157	9,698,103		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,142,242	2,326,122		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-14,886	2,666,228		54.00
54.01	03480	ONCOLOGY	0	0		54.01
54.02	05402	ULTRASOUND	0	275,615		54.02
57.00	05700	CT SCAN	-21,879	721,621		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-422	644,213		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	3,235,973		60.00
65.00	06500	RESPIRATORY THERAPY	-256	1,099,321		65.00
66.00	06600	PHYSICAL THERAPY	0	514,115		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	20,114		68.00
69.00	06900	ELECTROCARDIOLOGY	0	119,854		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	87,793		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,934,176		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,037,833		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,098,821		73.00
75.00	07500	ASC (NON-DISTINCT PART)	-495,001	9,235,240		75.00
76.00	03330	ENDOSCOPY	8,364	3,022,309		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-406	2,351,199		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-26,630,772	124,659,818		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	481,752		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	423,676		192.00
194.00	07950	MISSION EFFECTIVENESS	0	0		194.00
194.01	07951	MARKETING	677,023	677,023		194.01
194.02	07952	JOINT VENTURES	0	0		194.02
194.04	07954	SCHOOL NURSE	0	591,591		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	818,764		194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	-25,953,749	127,652,624		200.00

RECLASSIFICATIONS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 10:58 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - NURSERY					
1.00	NURSERY	43.00	910,050	201,714		1.00
	TOTALS		910,050	201,714		
	B - ACCRUED PTO					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	262,222	0		1.00
	TOTALS		262,222	0		
	C - CAFETERIA					
1.00	CAFETERIA	11.00	0	1,087,873		1.00
	TOTALS		0	1,087,873		
	D - INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,993		1.00
	TOTALS		0	8,993		
500.00	Grand Total: Increases		1,172,272	1,298,580		500.00

RECLASSIFICATIONS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 10:58 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	910,050	201,714	0		1.00
	TOTALS		910,050	201,714			
	B - ACCRUED PTO						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	262,222	0		1.00
	TOTALS		0	262,222			
	C - CAFETERIA						
1.00	DIETARY	10.00	0	1,087,873	0		1.00
	TOTALS		0	1,087,873			
	D - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,993	11		1.00
	TOTALS		0	8,993			
500.00	Grand Total: Decreases		910,050	1,560,802			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/26/2018 10:58 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	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	2,111,746	13,564,268	0	13,564,268	0	1.00
2.00	Land Improvements	2,431,023	56,948	0	56,948	0	2.00
3.00	Buildings and Fixtures	54,884,310	536,536	0	536,536	0	3.00
4.00	Building Improvements	56,374,578	1,933,830	0	1,933,830	14,513,431	4.00
5.00	Fixed Equipment	2,832,756	0	0	0	0	5.00
6.00	Movable Equipment	46,029,470	3,134,927	0	3,134,927	243,743	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	164,663,883	19,226,509	0	19,226,509	14,757,174	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	164,663,883	19,226,509	0	19,226,509	14,757,174	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	15,676,014	0	1.00
2.00	Land Improvements	2,487,971	1,877,961	2.00
3.00	Buildings and Fixtures	55,420,846	19,321,863	3.00
4.00	Building Improvements	43,794,977	1,281,787	4.00
5.00	Fixed Equipment	2,832,756	927,614	5.00
6.00	Movable Equipment	48,920,654	19,261,371	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	169,133,218	42,670,596	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	169,133,218	42,670,596	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II Date/Time Prepared: 11/26/2018 10:58 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,517,731	4,064,127	727,186	73,887	402,174	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,502,221	461,726	0	7,478	2,032	2.00
3.00	Total (sum of lines 1-2)	7,019,952	4,525,853	727,186	81,365	404,206	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	8,785,105		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,312	3,987,769		2.00
3.00	Total (sum of lines 1-2)	14,312	12,772,874		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/26/2018 10:58 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	120,212,474	0	120,212,474	0.710757	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	48,920,546	0	48,920,546	0.289243	0	2.00
3.00	Total (sum of lines 1-2)	169,133,020	0	169,133,020	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,514,278	3,324,283	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,502,221	461,726	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,016,499	3,786,009	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	73,887	402,174	21,816	7,336,438	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,478	2,032	28,624	4,002,081	2.00
3.00	Total (sum of lines 1-2)	0	81,365	404,206	50,440	11,338,519	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/26/2018 10:58 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-718,193	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)	B	-8,993	ADMINISTRATIVE & GENERAL	5.00	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)	A	-4,862	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,319,379			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	-11,150,108			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-442,708	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-1,220	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-4,439	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	CAFETERIA REVENUE - IMAGING	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/26/2018 10:58 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	CAFETERIA REVENUE - DIETARY	B	-51,638	DIETARY	10.00	0	33.01
33.02	CAFETERIA REVENUE - FITNESS CENTER	B	-3,453	CAP REL COSTS-BLDG & FIXT	1.00	9	33.02
33.03	CAFETERIA REVENUE - PHARMACY	B	0	PHARMACY	15.00	0	33.03
34.00	OTHER MISC REVENUE - BENEFITS	B	-5,117	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
35.00	OTHER MISC REVENUE - ADMIN	B	-3,389	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OTHER MISC REVENUE - MAINT	B	-65,831	OPERATION OF PLANT	7.00	0	36.00
37.00	OTHER MISC REVENUE - OR	B	0	OPERATING ROOM	50.00	0	37.00
38.00	OTHER MISC REVENUE - DIETARY	B	-666	DIETARY	10.00	0	38.00
38.01	OTHER MISC REVENUE - MED RECORDS	B	0	MEDICAL RECORDS & LIBRARY	16.00	0	38.01
39.00	OTHER MISC REVENUE - ROUTINE	B	-132,010	ADULTS & PEDIATRICS	30.00	0	39.00
40.00	OTHER MISC REVENUE - NEONATOLOGY	B	-10	NEONATAL INTENSIVE CARE UNIT	35.00	0	40.00
41.00	OTHER MISC REVENUE - RADIOLOGY	B	-1,700	RADIOLOGY-DIAGNOSTIC	54.00	0	41.00
42.00	OTHER MISC REVENUE - ASC	B	-495,001	ASC (NON-DISTINCT PART)	75.00	0	42.00
42.01	OTHER MISC REVENUE - ENDO	B	8,364	ENDOSCOPY	76.00	0	42.01
43.00	PROPERTY RENTAL INCOME	B	-739,844	CAP REL COSTS-BLDG & FIXT	1.00	10	43.00
44.00	PROVIDER ASSESSMENT OFFSET	B	-6,100,802	ADMINISTRATIVE & GENERAL	5.00	0	44.00
44.01	UNCLAIMED PROPERTY EXEMPTIONS`	B	-4,698	ADMINISTRATIVE & GENERAL	5.00	0	44.01
45.00	LOBBYING	A	-1,486	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	LOSS ON SALE DISPOSAL PPE	A	14,312	CAP REL COSTS-MVBLE EQUIP	2.00	14	46.00
47.00	CONSOLIDATING ENTRY	B	-1,425,032	ADMINISTRATIVE & GENERAL	5.00	0	47.00
49.00	IFUE OPERATING COMFORT IMAGING	B	23,833	CAP REL COSTS-BLDG & FIXT	1.00	14	49.00
49.01	ENTERTAINMENT EXP - HR	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.01
49.02	ENTERTAINMENT EXP - ADMIN	A	-9,600	ADMINISTRATIVE & GENERAL	5.00	0	49.02
49.03	ENTERTAINMENT EXP - NURS ADMIN	A	0	NURSING ADMINISTRATION	13.00	0	49.03
49.04	ENTERTAINMENT EXP - PHARMACY	A	-228	PHARMACY	15.00	0	49.04
49.05	ENTERTAINMENT EXP - ROUTINE	A	0	ADULTS & PEDIATRICS	30.00	0	49.05
49.06	ENTERTAINMENT EXP - OR	A	-157	OPERATING ROOM	50.00	0	49.06
49.07	ENTERTAINMENT EXP - RADIOLOGY	A	-42	RADIOLOGY-DIAGNOSTIC	54.00	0	49.07
49.08	ENTERTAINMENT EXP - RT	A	-256	RESPIRATORY THERAPY	65.00	0	49.08
49.09	ENTERTAINMENT EXP - ED	A	-406	EMERGENCY	91.00	0	49.09
49.10	CORP SPONSORSHIP - ADMIN	A	0	ADMINISTRATIVE & GENERAL	5.00	0	49.10
49.11	MARKETING - ADMIN	A	-25,678	ADMINISTRATIVE & GENERAL	5.00	0	49.11
49.12	MARKETING - ROUTINE	A	-13,753	ADULTS & PEDIATRICS	30.00	0	49.12
49.13	MARKETING - LABOR & DEL	A	-84	DELIVERY ROOM & LABOR ROOM	52.00	0	49.13
49.14	PROMOTIONAL ITEMS - ADMIN	A	1,343	ADMINISTRATIVE & GENERAL	5.00	0	49.14
49.15	PROMOTIONAL ITEMS - LABOR & DEL	A	0	DELIVERY ROOM & LABOR ROOM	52.00	0	49.15
49.16	PROMOTIONAL ITEMS - ER	A	0	EMERGENCY	91.00	0	49.16
49.17	CHARITABLE EXP - ADMIN	A	-1,250	ADMINISTRATIVE & GENERAL	5.00	0	49.17
49.18	CHARITABLE EXP - PHARMACY	A	-1,977	PHARMACY	15.00	0	49.18
49.19	CHARITABLE EXP - SOC SVC	A	-14,192	SOCIAL SERVICE	17.00	0	49.19
49.20	INCENTIVE PYMT ADJ - SALARY	A	26,181	ADMINISTRATIVE & GENERAL	5.00	0	49.20
49.21	INCENTIVE PYMT ADJ - BENEFITS	A	29,527	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.21
49.22	TELEPHONE OFFSET - DEPR	A	-2,017	CAP REL COSTS-BLDG & FIXT	1.00	14	49.22
49.23	DONATIONS MADE - A&G	A	-307,090	ADMINISTRATIVE & GENERAL	5.00	0	49.23
49.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.24
49.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.25
49.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.26
49.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.27
49.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.28
49.29	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.29
49.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.30
49.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.31
49.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.32
49.33	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.33
49.34	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.34

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/26/2018 10:58 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-25,953,749				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/26/2018 10:58 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	H.O. COSTS	23,427,835	35,254,966	2.00
3.00	194.01	MARKETING	H.O. COSTS MARKETING	677,023	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACK	1,513,553	1,513,553	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK	230,059	230,059	3.02
3.03	13.00	NURSING ADMINISTRATION	SVH CHARGEBACK	5,233	5,233	3.03
3.04	15.00	PHARMACY	SVH CHARGEBACK	-134,327	-134,327	3.04
3.05	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACK	226,259	226,259	3.05
3.06	31.00	INTENSIVE CARE UNIT	SVH CHARGEBACK	401,500	401,500	3.06
3.07	35.00	NEONATAL INTENSIVE CARE UNIT	SVH CHARGEBACK	167,849	167,849	3.07
3.08	50.00	OPERATING ROOM	SVH CHARGEBACK	675	675	3.08
3.09	52.00	DELIVERY ROOM & LABOR ROOM	SVH CHARGEBACK	150	150	3.09
3.10	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	77,779	77,779	3.10
3.11	65.00	RESPIRATORY THERAPY	SVH CHARGEBACK	50	50	3.11
3.12	66.00	PHYSICAL THERAPY	SVH CHARGEBACK	39,794	39,794	3.12
3.13	70.00	ELECTROENCEPHALOGRAPHY	SVH CHARGEBACK	3,808	3,808	3.13
4.00	76.00	ENDOSCOPY	SVH CHARGEBACK	50	50	4.00
4.01	91.00	EMERGENCY	SVH CHARGEBACK	225	225	4.01
4.02	190.00	GIFT, FLOWER, COFFEE SHOP &	SVH CHARGEBACK	18,321	18,321	4.02
4.14	194.04	SCHOOL NURSE	SVH CHARGEBACK	50	50	4.14
4.15	0.00		0	0	0	4.15
4.16	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	727,186	727,186	4.16
4.17	0.00		0	0	0	4.17
4.18	0.00		0	0	0	4.18
4.20	0.00			0	0	4.20
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			27,383,072	38,533,180	5.00

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

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

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

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

6.00	G	ST. VINCENT HEA	100.00	ST. VINCENT HEA	100.00	6.00
7.00	G	ASCENSION HEALT	100.00	ASCENSION HEALT	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/26/2018 10:58 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	-11,827,131	0		2.00
3.00	677,023	0		3.00
3.01	0	9		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
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	11		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.20	0	0		4.20
5.00	-11,150,108			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	HOME OFFICE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/26/2018 10:58 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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,466,202	2,124,331	341,871	211,500	9,121	2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	1,017,445	1,017,445	0	0	0	3.00
4.00	50.00	OPERATING ROOM	1,014,364	0	1,014,364	246,400	21,984	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	1,142,158	1,142,158	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	52,099	0	52,099	271,900	298	6.00
7.00	57.00	CT SCAN	21,879	21,879	0	0	0	7.00
8.00	91.00	EMERGENCY	51,053	0	51,053	211,500	1,225	8.00
9.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	422	422	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,765,622	4,306,235	1,459,387		32,628	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	927,448	46,372	0	0	0	2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	2,604,259	130,213	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	38,955	1,948	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	124,561	6,228	0	0	0	8.00
9.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,695,223	184,761	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	927,448	0	2,124,331		2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	1,017,445		3.00
4.00	50.00	OPERATING ROOM	0	2,604,259	0	0		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	1,142,158		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	38,955	13,144	13,144		6.00
7.00	57.00	CT SCAN	0	0	0	21,879		7.00
8.00	91.00	EMERGENCY	0	124,561	0	0		8.00
9.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	422		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	3,695,223	13,144	4,319,379		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/26/2018 10:58 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,336,438	7,336,438				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,002,081		4,002,081			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,277,095	96,546	0	10,373,641		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,597,912	466,125	487,484	1,230,930	27,782,451	5.00
7.00	00700	OPERATION OF PLANT	4,671,701	856,899	47,268	64,848	5,640,716	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	663,087	48,878	0	0	711,965	8.00
9.00	00900	HOUSEKEEPING	1,636,402	120,627	3,319	0	1,760,348	9.00
10.00	01000	DIETARY	801,492	161,140	5,261	0	967,893	10.00
11.00	01100	CAFETERIA	640,726	188,009	6,703	0	835,438	11.00
13.00	01300	NURSING ADMINISTRATION	1,524,587	3,380	79,406	320,611	1,927,984	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	390,350	163,435	51,450	83,466	688,701	14.00
15.00	01500	PHARMACY	2,669,649	128,621	245,598	527,950	3,571,818	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,893	7,476	0	3,801	27,170	16.00
17.00	01700	SOCIAL SERVICE	245,144	17,740	0	39,288	302,172	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,539,636	1,686,359	263,008	2,383,909	13,872,912	30.00
31.00	03100	INTENSIVE CARE UNIT	1,612,323	170,467	32,536	250,550	2,065,876	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,834,888	169,677	26,677	582,226	2,613,468	35.00
43.00	04300	NURSERY	1,111,764	278,881	14,405	233,347	1,638,397	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,698,103	654,135	1,381,365	1,009,113	12,742,716	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,326,122	347,472	70,753	545,625	3,289,972	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,666,228	344,931	272,241	442,362	3,725,762	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	275,615	11,547	68,163	64,120	419,445	54.02
57.00	05700	CT SCAN	721,621	98,619	192,210	138,833	1,151,283	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	644,213	196,596	49,635	91,684	982,128	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,235,973	119,097	4,654	0	3,359,724	60.00
65.00	06500	RESPIRATORY THERAPY	1,099,321	56,773	79,075	236,979	1,472,148	65.00
66.00	06600	PHYSICAL THERAPY	514,115	48,532	0	118,698	681,345	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	20,114	1,900	0	3,867	25,881	68.00
69.00	06900	ELECTROCARDIOLOGY	119,854	4,959	15,546	25,015	165,374	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	87,793	3,627	24,289	18,835	134,544	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,934,176	0	0	0	4,934,176	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,037,833	0	0	0	6,037,833	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,098,821	0	0	0	3,098,821	73.00
75.00	07500	ASC (NON-DISTINCT PART)	9,235,240	312,782	204,039	690,012	10,442,073	75.00
76.00	03330	ENDOSCOPY	3,022,309	129,805	277,285	400,762	3,830,161	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,351,199	335,925	67,114	445,845	3,200,083	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	124,659,818	7,230,960	3,969,484	9,952,676	124,100,778	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	481,752	40,809	669	29,611	552,841	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	423,676	0	0	91,023	514,699	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	677,023	0	0	0	677,023	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	591,591	21,836	0	141,521	754,948	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	818,764	42,833	31,928	158,810	1,052,335	194.06
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)	127,652,624	7,336,438	4,002,081	10,373,641	127,652,624	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 10:58 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,782,451					5.00
7.00	00700	OPERATION OF PLANT	1,569,168	7,209,884				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	198,059	59,559	969,583			8.00
9.00	00900	HOUSEKEEPING	489,704	146,988	0	2,397,040		9.00
10.00	01000	DIETARY	269,254	196,354	0	67,206	1,500,707	10.00
11.00	01100	CAFETERIA	232,407	229,095	0	78,413	0	11.00
13.00	01300	NURSING ADMINISTRATION	536,338	4,119	0	1,410	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	191,587	199,150	25,911	68,163	0	14.00
15.00	01500	PHARMACY	993,630	156,729	0	53,644	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,558	9,110	0	3,118	0	16.00
17.00	01700	SOCIAL SERVICE	84,060	21,617	0	7,399	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,859,216	2,054,879	335,409	703,328	1,362,150	30.00
31.00	03100	INTENSIVE CARE UNIT	574,698	207,719	36,902	71,096	52,730	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	727,030	206,757	0	70,767	0	35.00
43.00	04300	NURSERY	455,779	339,825	87,460	116,312	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,544,845	797,083	104,922	272,818	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	915,224	423,405	26,292	144,919	85,827	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,036,455	420,308	56,366	143,859	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	116,684	14,070	5,796	4,816	0	54.02
57.00	05700	CT SCAN	320,271	120,170	15,633	41,131	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	273,214	239,558	36,607	81,994	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	934,628	145,124	0	49,672	0	60.00
65.00	06500	RESPIRATORY THERAPY	409,531	69,180	1,167	23,678	0	65.00
66.00	06600	PHYSICAL THERAPY	189,541	59,138	1,019	20,241	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,200	2,315	37	792	0	68.00
69.00	06900	ELECTROCARDIOLOGY	46,005	6,043	123	2,068	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	37,428	4,420	98	1,513	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,372,619	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,679,641	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	862,049	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,904,839	381,134	46,272	130,451	0	75.00
76.00	03330	ENDOSCOPY	1,065,497	158,172	59,755	54,138	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	890,218	409,335	123,477	140,103	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,794,377	7,081,356	963,246	2,353,049	1,500,707	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	153,793	49,727	0	17,020	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	143,182	0	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	188,338	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	210,016	26,608	0	9,107	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	292,745	52,193	6,337	17,864	0	194.06
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)	27,782,451	7,209,884	969,583	2,397,040	1,500,707	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/26/2018 10:58 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,375,353					11.00
13.00	01300	NURSING ADMINISTRATION	43,173	2,513,024				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	21,626	0	1,195,138			14.00
15.00	01500	PHARMACY	66,380	0	8,996	4,851,197		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	557	0	0	0	47,513	16.00
17.00	01700	SOCIAL SERVICE	6,388	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	348,636	949,525	18,864	0	4,469	30.00
31.00	03100	INTENSIVE CARE UNIT	36,463	99,307	3,878	0	515	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	57,199	155,784	5,169	0	1,317	35.00
43.00	04300	NURSERY	40,083	109,167	2,755	0	801	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	165,657	451,174	247,572	0	14,477	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	84,295	229,580	12,144	0	3,016	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,203	0	28,281	0	2,439	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	7,707	0	182	0	308	54.02
57.00	05700	CT SCAN	20,149	0	5,828	0	847	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,974	0	5,443	0	325	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	3,642	60.00
65.00	06500	RESPIRATORY THERAPY	41,371	0	5,205	0	402	65.00
66.00	06600	PHYSICAL THERAPY	19,441	0	378	0	255	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	568	0	30	0	11	68.00
69.00	06900	ELECTROCARDIOLOGY	3,052	0	931	0	443	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,969	0	337	0	151	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	289,211	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	362,796	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,848,443	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	136,446	0	146,116	0	5,872	75.00
76.00	03330	ENDOSCOPY	64,755	176,362	35,963	0	3,806	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	66,512	181,149	14,549	0	4,417	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,328,604	2,352,048	1,194,628	4,848,443	47,513	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,463	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,680	0	24	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	88,514	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	26,606	72,462	486	2,754	0	194.06
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)	1,375,353	2,513,024	1,195,138	4,851,197	47,513	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 10:58 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
17.00	01700	SOCIAL SERVICE	421,636					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	94,637	23,604,025	0	23,604,025		30.00
31.00	03100	INTENSIVE CARE UNIT	43,268	3,192,452	0	3,192,452		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	70,242	3,907,733	0	3,907,733		35.00
43.00	04300	NURSERY	0	2,790,579	0	2,790,579		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,283	18,349,547	0	18,349,547		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,342	5,268,016	0	5,268,016		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,492,673	0	5,492,673		54.00
54.01	03480	ONCOLOGY	0	0	0	0		54.01
54.02	05402	ULTRASOUND	0	569,008	0	569,008		54.02
57.00	05700	CT SCAN	0	1,675,312	0	1,675,312		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,635,243	0	1,635,243		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	4,492,790	0	4,492,790		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,022,682	0	2,022,682		65.00
66.00	06600	PHYSICAL THERAPY	0	971,358	0	971,358		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	36,834	0	36,834		68.00
69.00	06900	ELECTROCARDIOLOGY	0	224,039	0	224,039		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	181,460	0	181,460		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,596,006	0	6,596,006		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,080,270	0	8,080,270		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,809,313	0	8,809,313		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	14,193,203	0	14,193,203		75.00
76.00	03330	ENDOSCOPY	22,089	5,470,698	0	5,470,698		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	107,655	5,137,498	0	5,137,498		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	399,516	122,700,739	0	122,700,739		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	781,844	0	781,844		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,120	691,705	0	691,705		192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0		194.00
194.01	07951	MARKETING	0	865,361	0	865,361		194.01
194.02	07952	JOINT VENTURES	0	0	0	0		194.02
194.04	07954	SCHOOL NURSE	0	1,089,193	0	1,089,193		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	1,523,782	0	1,523,782		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	421,636	127,652,624	0	127,652,624		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 10:58 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	96,546	0	96,546	96,546	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,384,462	466,125	487,484	3,338,071	11,454	5.00
7.00	00700	OPERATION OF PLANT	0	856,899	47,268	904,167	603	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	48,878	0	48,878	0	8.00
9.00	00900	HOUSEKEEPING	0	120,627	3,319	123,946	0	9.00
10.00	01000	DIETARY	0	161,140	5,261	166,401	0	10.00
11.00	01100	CAFETERIA	0	188,009	6,703	194,712	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,380	79,406	82,786	2,983	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	163,435	51,450	214,885	777	14.00
15.00	01500	PHARMACY	0	128,621	245,598	374,219	4,913	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,476	0	7,476	35	16.00
17.00	01700	SOCIAL SERVICE	0	17,740	0	17,740	366	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,686,359	263,008	1,949,367	22,199	30.00
31.00	03100	INTENSIVE CARE UNIT	0	170,467	32,536	203,003	2,331	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	169,677	26,677	196,354	5,418	35.00
43.00	04300	NURSERY	0	278,881	14,405	293,286	2,171	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	654,135	1,381,365	2,035,500	9,390	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	347,472	70,753	418,225	5,077	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	344,931	272,241	617,172	4,116	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	11,547	68,163	79,710	597	54.02
57.00	05700	CT SCAN	0	98,619	192,210	290,829	1,292	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	196,596	49,635	246,231	853	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	119,097	4,654	123,751	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	56,773	79,075	135,848	2,205	65.00
66.00	06600	PHYSICAL THERAPY	0	48,532	0	48,532	1,105	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,900	0	1,900	36	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,959	15,546	20,505	233	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,627	24,289	27,916	175	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	312,782	204,039	516,821	6,421	75.00
76.00	03330	ENDOSCOPY	0	129,805	277,285	407,090	3,729	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	335,925	67,114	403,039	4,149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,384,462	7,230,960	3,969,484	13,584,906	92,628	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40,809	669	41,478	276	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	847	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	21,836	0	21,836	1,317	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	42,833	31,928	74,761	1,478	194.06
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)	2,384,462	7,336,438	4,002,081	13,722,981	96,546	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/26/2018 10:58 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,349,525					5.00
7.00	00700	OPERATION OF PLANT	189,184	1,093,954				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,879	9,037	81,794			8.00
9.00	00900	HOUSEKEEPING	59,040	22,302	0	205,288		9.00
10.00	01000	DIETARY	32,462	29,793	0	5,756	234,412	10.00
11.00	01100	CAFETERIA	28,020	34,761	0	6,715	0	11.00
13.00	01300	NURSING ADMINISTRATION	64,663	625	0	121	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,098	30,217	2,186	5,838	0	14.00
15.00	01500	PHARMACY	119,795	23,780	0	4,594	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	911	1,382	0	267	0	16.00
17.00	01700	SOCIAL SERVICE	10,135	3,280	0	634	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	465,264	311,789	28,296	60,234	212,769	30.00
31.00	03100	INTENSIVE CARE UNIT	69,287	31,517	3,113	6,089	8,237	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	87,653	31,371	0	6,061	0	35.00
43.00	04300	NURSERY	54,950	51,561	7,378	9,961	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	427,378	120,941	8,851	23,365	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	110,342	64,243	2,218	12,411	13,406	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	124,958	63,773	4,755	12,320	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	14,068	2,135	489	412	0	54.02
57.00	05700	CT SCAN	38,613	18,233	1,319	3,523	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	32,940	36,348	3,088	7,022	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	112,682	22,020	0	4,254	0	60.00
65.00	06500	RESPIRATORY THERAPY	49,374	10,497	98	2,028	0	65.00
66.00	06600	PHYSICAL THERAPY	22,852	8,973	86	1,733	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	868	351	3	68	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,546	917	10	177	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,512	671	8	130	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	165,487	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	202,503	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	103,931	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	350,217	57,829	3,903	11,172	0	75.00
76.00	03330	ENDOSCOPY	128,460	23,999	5,041	4,636	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	107,328	62,108	10,417	11,999	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,230,400	1,074,453	81,259	201,520	234,412	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,542	7,545	0	1,458	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,262	0	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	22,707	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	25,320	4,037	0	780	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	35,294	7,919	535	1,530	0	194.06
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)	3,349,525	1,093,954	81,794	205,288	234,412	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 10:58 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	264,208					11.00
13.00	01300	NURSING ADMINISTRATION	8,294	159,472				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,154	0	281,155			14.00
15.00	01500	PHARMACY	12,752	0	2,116	542,169		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	107	0	0	0	10,178	16.00
17.00	01700	SOCIAL SERVICE	1,227	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	66,972	60,254	4,438	0	941	30.00
31.00	03100	INTENSIVE CARE UNIT	7,005	6,302	912	0	108	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	10,988	9,886	1,216	0	277	35.00
43.00	04300	NURSERY	7,700	6,928	648	0	169	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,823	28,631	58,243	0	3,223	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,193	14,569	2,857	0	635	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,215	0	6,653	0	514	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	1,481	0	43	0	65	54.02
57.00	05700	CT SCAN	3,871	0	1,371	0	178	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,069	0	1,281	0	68	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	767	60.00
65.00	06500	RESPIRATORY THERAPY	7,948	0	1,225	0	85	65.00
66.00	06600	PHYSICAL THERAPY	3,735	0	89	0	54	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	109	0	7	0	2	68.00
69.00	06900	ELECTROCARDIOLOGY	586	0	219	0	93	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	570	0	79	0	32	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	68,038	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	85,341	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	541,861	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	26,211	0	34,375	0	1,236	75.00
76.00	03330	ENDOSCOPY	12,440	11,192	8,461	0	801	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	12,777	11,495	3,423	0	930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	255,227	149,257	281,035	541,861	10,178	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,626	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,244	0	6	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	5,617	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	5,111	4,598	114	308	0	194.06
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)	264,208	159,472	281,155	542,169	10,178	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/26/2018 10:58 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
17.00	01700	SOCIAL SERVICE	33,382					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,493	3,190,016	0	3,190,016		30.00
31.00	03100	INTENSIVE CARE UNIT	3,426	341,330	0	341,330		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	5,561	354,785	0	354,785		35.00
43.00	04300	NURSERY	0	434,752	0	434,752		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	656	2,748,001	0	2,748,001		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,223	664,399	0	664,399		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	849,476	0	849,476		54.00
54.01	03480	ONCOLOGY	0	0	0	0		54.01
54.02	05402	ULTRASOUND	0	99,000	0	99,000		54.02
57.00	05700	CT SCAN	0	359,229	0	359,229		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	330,900	0	330,900		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	263,474	0	263,474		60.00
65.00	06500	RESPIRATORY THERAPY	0	209,308	0	209,308		65.00
66.00	06600	PHYSICAL THERAPY	0	87,159	0	87,159		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	3,344	0	3,344		68.00
69.00	06900	ELECTROCARDIOLOGY	0	28,286	0	28,286		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	34,093	0	34,093		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	233,525	0	233,525		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	287,844	0	287,844		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	645,792	0	645,792		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	1,008,185	0	1,008,185		75.00
76.00	03330	ENDOSCOPY	1,749	607,598	0	607,598		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,523	636,188	0	636,188		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,631	13,416,684	0	13,416,684		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	70,925	0	70,925		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,751	22,110	0	22,110		192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0		194.00
194.01	07951	MARKETING	0	22,707	0	22,707		194.01
194.02	07952	JOINT VENTURES	0	0	0	0		194.02
194.04	07954	SCHOOL NURSE	0	58,907	0	58,907		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	131,648	0	131,648		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	33,382	13,722,981	0	13,722,981		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 10:58 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	297,345					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,898,512				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,913	0	40,457,144			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,892	474,869	4,800,612	-27,782,451	99,870,173	5.00
7.00	00700	OPERATION OF PLANT	34,730	46,045	252,905	0	5,640,716	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,981	0	0	0	711,965	8.00
9.00	00900	HOUSEKEEPING	4,889	3,233	0	0	1,760,348	9.00
10.00	01000	DIETARY	6,531	5,125	0	0	967,893	10.00
11.00	01100	CAFETERIA	7,620	6,530	0	0	835,438	11.00
13.00	01300	NURSING ADMINISTRATION	137	77,351	1,250,381	0	1,927,984	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,624	50,119	325,517	0	688,701	14.00
15.00	01500	PHARMACY	5,213	239,242	2,058,999	0	3,571,818	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303	0	14,825	0	27,170	16.00
17.00	01700	SOCIAL SERVICE	719	0	153,223	0	302,172	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	68,348	256,202	9,297,282	0	13,872,912	30.00
31.00	03100	INTENSIVE CARE UNIT	6,909	31,694	977,143	0	2,065,876	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,877	25,987	2,270,674	0	2,613,468	35.00
43.00	04300	NURSERY	11,303	14,032	910,050	0	1,638,397	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,512	1,345,613	3,935,529	0	12,742,716	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,083	68,922	2,127,930	0	3,289,972	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,980	265,196	1,725,208	0	3,725,762	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	468	66,399	250,069	0	419,445	54.02
57.00	05700	CT SCAN	3,997	187,236	541,446	0	1,151,283	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	48,351	357,565	0	982,128	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,827	4,534	0	0	3,359,724	60.00
65.00	06500	RESPIRATORY THERAPY	2,301	77,029	924,214	0	1,472,148	65.00
66.00	06600	PHYSICAL THERAPY	1,967	0	462,920	0	681,345	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	77	0	15,082	0	25,881	68.00
69.00	06900	ELECTROCARDIOLOGY	201	15,144	97,559	0	165,374	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	147	23,660	73,457	0	134,544	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,934,176	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,037,833	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,098,821	73.00
75.00	07500	ASC (NON-DISTINCT PART)	12,677	198,759	2,691,038	0	10,442,073	75.00
76.00	03330	ENDOSCOPY	5,261	270,109	1,562,968	0	3,830,161	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,615	65,377	1,738,792	0	3,200,083	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	293,070	3,866,758	38,815,388	-27,782,451	96,318,327	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	652	115,481	0	552,841	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	354,989	0	514,699	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	677,023	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	885	0	551,929	0	754,948	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,736	31,102	619,357	0	1,052,335	194.06
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)	7,336,438	4,002,081	10,373,641		27,782,451	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.673151	1.026566	0.256411		0.278186	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			96,546		3,349,525	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002386		0.033539	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: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 10:58 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	239,810					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,981	78,955				8.00
9.00	00900	HOUSEKEEPING	4,889	0	232,940			9.00
10.00	01000	DIETARY	6,531	0	6,531	45,479		10.00
11.00	01100	CAFETERIA	7,620	0	7,620	0	943,667	11.00
13.00	01300	NURSING ADMINISTRATION	137	0	137	0	29,622	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,624	2,110	6,624	0	14,838	14.00
15.00	01500	PHARMACY	5,213	0	5,213	0	45,545	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303	0	303	0	382	16.00
17.00	01700	SOCIAL SERVICE	719	0	719	0	4,383	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	68,348	27,313	68,348	41,280	239,209	30.00
31.00	03100	INTENSIVE CARE UNIT	6,909	3,005	6,909	1,598	25,018	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,877	0	6,877	0	39,246	35.00
43.00	04300	NURSERY	11,303	7,122	11,303	0	27,502	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,512	8,544	26,512	0	113,662	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,083	2,141	14,083	2,601	57,837	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,980	4,590	13,980	0	54,343	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	468	472	468	0	5,288	54.02
57.00	05700	CT SCAN	3,997	1,273	3,997	0	13,825	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	2,981	7,968	0	10,960	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,827	0	4,827	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,301	95	2,301	0	28,386	65.00
66.00	06600	PHYSICAL THERAPY	1,967	83	1,967	0	13,339	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	77	3	77	0	390	68.00
69.00	06900	ELECTROCARDIOLOGY	201	10	201	0	2,094	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	147	8	147	0	2,037	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	12,677	3,768	12,677	0	93,619	75.00
76.00	03330	ENDOSCOPY	5,261	4,866	5,261	0	44,430	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,615	10,055	13,615	0	45,636	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	235,535	78,439	228,665	45,479	911,591	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	0	1,654	0	5,807	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	8,014	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	885	0	885	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,736	516	1,736	0	18,255	194.06
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)	7,209,884	969,583	2,397,040	1,500,707	1,375,353	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.064985	12.280198	10.290375	32.997801	1.457456	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,093,954	81,794	205,288	234,412	264,208	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.561753	1.035957	0.881291	5.154291	0.279980	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: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 10:58 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT REVENUE)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
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	633,094					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,889,885				14.00
15.00	01500	PHARMACY	0	149,707	3,100,581			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	499,729,742		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	13,896	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	239,209	313,947	0	47,045,440	3,119	30.00
31.00	03100	INTENSIVE CARE UNIT	25,018	64,539	0	5,420,676	1,426	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	39,246	86,031	0	13,864,608	2,315	35.00
43.00	04300	NURSERY	27,502	45,847	0	8,426,892	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	113,662	4,120,157	0	151,978,222	273	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	57,837	202,110	0	31,752,186	1,758	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	470,667	0	25,678,486	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	3,026	0	3,244,590	0	54.02
57.00	05700	CT SCAN	0	96,986	0	8,912,227	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	90,587	0	3,422,719	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	38,336,721	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	86,629	0	4,227,954	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,284	0	2,683,275	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	491	0	111,536	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	15,488	0	4,659,629	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,609	0	1,594,203	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,813,124	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,037,833	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,098,821	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	2,431,702	0	61,805,742	0	75.00
76.00	03330	ENDOSCOPY	44,430	598,510	0	40,068,414	728	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	45,636	242,122	0	46,496,222	3,548	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	592,540	19,881,396	3,098,821	499,729,742	13,167	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	398	0	0	729	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	22,299	0	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	18,255	8,091	1,760	0	0	194.06
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)	2,513,024	1,195,138	4,851,197	47,513	421,636	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.969433	0.060088	1.564609	0.000095	30.342257	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	159,472	281,155	542,169	10,178	33,382	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.251893	0.014136	0.174860	0.000020	2.402274	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: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 10:58 am

Title XVIII | Hospital | PPS

		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	23,604,025		23,604,025	0	23,604,025	30.00
31.00	03100	INTENSIVE CARE UNIT	3,192,452		3,192,452	0	3,192,452	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	3,907,733		3,907,733	0	3,907,733	35.00
43.00	04300	NURSERY	2,790,579		2,790,579	0	2,790,579	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,349,547		18,349,547	0	18,349,547	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,268,016		5,268,016	0	5,268,016	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,492,673		5,492,673	13,144	5,505,817	54.00
54.01	03480	ONCOLOGY	0		0	0	0	54.01
54.02	05402	ULTRASOUND	569,008		569,008	0	569,008	54.02
57.00	05700	CT SCAN	1,675,312		1,675,312	0	1,675,312	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,635,243		1,635,243	0	1,635,243	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,492,790		4,492,790	0	4,492,790	60.00
65.00	06500	RESPIRATORY THERAPY	2,022,682	0	2,022,682	0	2,022,682	65.00
66.00	06600	PHYSICAL THERAPY	971,358	0	971,358	0	971,358	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	36,834	0	36,834	0	36,834	68.00
69.00	06900	ELECTROCARDIOLOGY	224,039		224,039	0	224,039	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	181,460		181,460	0	181,460	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,596,006		6,596,006	0	6,596,006	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,080,270		8,080,270	0	8,080,270	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,809,313		8,809,313	0	8,809,313	73.00
75.00	07500	ASC (NON-DISTINCT PART)	14,193,203		14,193,203	0	14,193,203	75.00
76.00	03330	ENDOSCOPY	5,470,698		5,470,698	0	5,470,698	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,137,498		5,137,498	0	5,137,498	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,376,372		3,376,372		3,376,372	92.00
200.00		Subtotal (see instructions)	126,077,111	0	126,077,111	13,144	126,090,255	200.00
201.00		Less Observation Beds	3,376,372		3,376,372		3,376,372	201.00
202.00		Total (see instructions)	122,700,739	0	122,700,739	13,144	122,713,883	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 10:58 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	38,095,633		38,095,633			30.00
31.00	03100	INTENSIVE CARE UNIT	5,420,676		5,420,676			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	13,864,608		13,864,608			35.00
43.00	04300	NURSERY	8,426,892		8,426,892			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,662,750	92,315,472	151,978,222	0.120738	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,048,885	703,301	31,752,186	0.165910	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,393,188	23,285,297	25,678,485	0.213902	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	54.01
54.02	05402	ULTRASOUND	399,392	2,845,198	3,244,590	0.175371	0.000000	54.02
57.00	05700	CT SCAN	1,485,889	7,426,338	8,912,227	0.187979	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	182,330	3,240,389	3,422,719	0.477761	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	15,680,594	22,656,127	38,336,721	0.117193	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,137,757	1,090,197	4,227,954	0.478407	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,169,766	1,513,510	2,683,276	0.362005	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	77,262	34,274	111,536	0.330243	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	755,931	3,903,699	4,659,630	0.048081	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,045,694	548,509	1,594,203	0.113825	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,160,481	29,654,686	42,815,167	0.154058	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,577,796	6,731,195	26,308,991	0.307130	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,914,429	12,021,327	28,935,756	0.304444	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	428,688	61,377,054	61,805,742	0.229642	0.000000	75.00
76.00	03330	ENDOSCOPY	1,776,468	38,291,946	40,068,414	0.136534	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,692,750	39,803,472	46,496,222	0.110493	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,367,930	7,581,877	8,949,807	0.377256	0.000000	92.00
200.00		Subtotal (see instructions)	242,765,789	355,023,868	597,789,657			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	242,765,789	355,023,868	597,789,657			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 10:58 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
35.00	02060	NEONATAL INTENSIVE CARE UNIT		35.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.120738	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.165910	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214414	54.00
54.01	03480	ONCOLOGY	0.000000	54.01
54.02	05402	ULTRASOUND	0.175371	54.02
57.00	05700	CT SCAN	0.187979	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.477761	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.117193	60.00
65.00	06500	RESPIRATORY THERAPY	0.478407	65.00
66.00	06600	PHYSICAL THERAPY	0.362005	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.330243	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048081	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.113825	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.154058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307130	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304444	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.229642	75.00
76.00	03330	ENDOSCOPY	0.136534	76.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.110493	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.377256	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 10:58 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	23,604,025		23,604,025	0	23,604,025	30.00
31.00	03100	INTENSIVE CARE UNIT	3,192,452		3,192,452	0	3,192,452	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	3,907,733		3,907,733	0	3,907,733	35.00
43.00	04300	NURSERY	2,790,579		2,790,579	0	2,790,579	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,349,547		18,349,547	0	18,349,547	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,268,016		5,268,016	0	5,268,016	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,492,673		5,492,673	13,144	5,505,817	54.00
54.01	03480	ONCOLOGY	0		0	0	0	54.01
54.02	05402	ULTRASOUND	569,008		569,008	0	569,008	54.02
57.00	05700	CT SCAN	1,675,312		1,675,312	0	1,675,312	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,635,243		1,635,243	0	1,635,243	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,492,790		4,492,790	0	4,492,790	60.00
65.00	06500	RESPIRATORY THERAPY	2,022,682	0	2,022,682	0	2,022,682	65.00
66.00	06600	PHYSICAL THERAPY	971,358	0	971,358	0	971,358	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	36,834	0	36,834	0	36,834	68.00
69.00	06900	ELECTROCARDIOLOGY	224,039		224,039	0	224,039	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	181,460		181,460	0	181,460	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,596,006		6,596,006	0	6,596,006	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,080,270		8,080,270	0	8,080,270	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,809,313		8,809,313	0	8,809,313	73.00
75.00	07500	ASC (NON-DISTINCT PART)	14,193,203		14,193,203	0	14,193,203	75.00
76.00	03330	ENDOSCOPY	5,470,698		5,470,698	0	5,470,698	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,137,498		5,137,498	0	5,137,498	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,376,372		3,376,372		3,376,372	92.00
200.00		Subtotal (see instructions)	126,077,111	0	126,077,111	13,144	126,090,255	200.00
201.00		Less Observation Beds	3,376,372		3,376,372		3,376,372	201.00
202.00		Total (see instructions)	122,700,739	0	122,700,739	13,144	122,713,883	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 10:58 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	38,095,633		38,095,633			30.00
31.00	03100	INTENSIVE CARE UNIT	5,420,676		5,420,676			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	13,864,608		13,864,608			35.00
43.00	04300	NURSERY	8,426,892		8,426,892			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,662,750	92,315,472	151,978,222	0.120738	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,048,885	703,301	31,752,186	0.165910	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,393,188	23,285,297	25,678,485	0.213902	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	54.01
54.02	05402	ULTRASOUND	399,392	2,845,198	3,244,590	0.175371	0.000000	54.02
57.00	05700	CT SCAN	1,485,889	7,426,338	8,912,227	0.187979	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	182,330	3,240,389	3,422,719	0.477761	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	15,680,594	22,656,127	38,336,721	0.117193	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,137,757	1,090,197	4,227,954	0.478407	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,169,766	1,513,510	2,683,276	0.362005	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	77,262	34,274	111,536	0.330243	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	755,931	3,903,699	4,659,630	0.048081	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,045,694	548,509	1,594,203	0.113825	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,160,481	29,654,686	42,815,167	0.154058	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,577,796	6,731,195	26,308,991	0.307130	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,914,429	12,021,327	28,935,756	0.304444	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	428,688	61,377,054	61,805,742	0.229642	0.000000	75.00
76.00	03330	ENDOSCOPY	1,776,468	38,291,946	40,068,414	0.136534	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,692,750	39,803,472	46,496,222	0.110493	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,367,930	7,581,877	8,949,807	0.377256	0.000000	92.00
200.00		Subtotal (see instructions)	242,765,789	355,023,868	597,789,657			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	242,765,789	355,023,868	597,789,657			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 10:58 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
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03480	ONCOLOGY	0.000000		54.01
54.02	05402	ULTRASOUND	0.000000		54.02
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
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 PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03330	ENDOSCOPY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part I Date/Time Prepared: 11/26/2018 10:58 am

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	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	3,190,016	0	3,190,016	15,450	206.47	30.00
31.00	INTENSIVE CARE UNIT	341,330		341,330	794	429.89	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	354,785		354,785	2,024	175.29	35.00
43.00	NURSERY	434,752		434,752	2,892	150.33	43.00
200.00	Total (lines 30 through 199)	4,320,883		4,320,883	21,160		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,235	874,400				30.00
31.00	INTENSIVE CARE UNIT	345	148,312				31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				35.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	4,580	1,022,712				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/26/2018 10:58 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	2,748,001	151,978,222	0.018082	19,332,835	349,576	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	664,399	31,752,186	0.020925	2,169	45	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	849,476	25,678,485	0.033081	565,558	18,709	54.00
54.01	03480	ONCOLOGY	0	0	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	99,000	3,244,590	0.030512	129,771	3,960	54.02
57.00	05700	CT SCAN	359,229	8,912,227	0.040307	652,800	26,312	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	330,900	3,422,719	0.096678	65,402	6,323	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	263,474	38,336,721	0.006873	5,255,929	36,124	60.00
65.00	06500	RESPIRATORY THERAPY	209,308	4,227,954	0.049506	1,180,814	58,457	65.00
66.00	06600	PHYSICAL THERAPY	87,159	2,683,276	0.032482	520,496	16,907	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,344	111,536	0.029981	36,538	1,095	68.00
69.00	06900	ELECTROCARDIOLOGY	28,286	4,659,630	0.006070	494,336	3,001	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	34,093	1,594,203	0.021386	460,822	9,855	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	233,525	42,815,167	0.005454	3,097,995	16,896	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	287,844	26,308,991	0.010941	7,035,015	76,970	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	645,792	28,935,756	0.022318	4,755,885	106,142	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,008,185	61,805,742	0.016312	0	0	75.00
76.00	03330	ENDOSCOPY	607,598	40,068,414	0.015164	499,768	7,578	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	636,188	46,496,222	0.013683	3,034,511	41,521	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	456,307	8,949,807	0.050985	577,714	29,455	92.00
200.00		Total (lines 50 through 199)	9,552,108	531,981,848		47,698,358	808,926	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 11/26/2018 10:58 am

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		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
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00
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	15,450	0.00	4,235	30.00
31.00	03100	INTENSIVE CARE UNIT		0	794	0.00	345	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	2,024	0.00	0	35.00
43.00	04300	NURSERY		0	2,892	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	21,160		4,580	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
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	35.00
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: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 10:58 am

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		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	0	0	0	0	54.02
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 10:58 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 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	151,978,222	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	31,752,186	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	25,678,485	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0.000000	54.01
54.02	05402	ULTRASOUND	0	0	0	3,244,590	0.000000	54.02
57.00	05700	CT SCAN	0	0	0	8,912,227	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,422,719	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	38,336,721	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,227,954	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,683,276	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	111,536	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,659,630	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,594,203	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	42,815,167	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	26,308,991	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,935,756	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	61,805,742	0.000000	75.00
76.00	03330	ENDOSCOPY	0	0	0	40,068,414	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	46,496,222	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,949,807	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	531,981,848		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 10:58 am

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		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	19,332,835	0	12,370,078	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	2,169	0	10,917	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	565,558	0	1,628,495	0	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.000000	129,771	0	761,960	0	54.02
57.00	05700	CT SCAN	0.000000	652,800	0	2,082,913	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	65,402	0	762,771	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	5,255,929	0	5,412,737	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,180,814	0	411,356	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	520,496	0	64,878	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	36,538	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	494,336	0	1,049,156	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	460,822	0	110,971	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	3,097,995	0	1,710,619	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	7,035,015	0	702,747	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,755,885	0	2,919,667	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0.000000	499,768	0	4,405,641	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	3,034,511	0	7,853,233	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	577,714	0	2,080,131	0	92.00
200.00		Total (lines 50 through 199)		47,698,358	0	44,338,270	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 10:58 am

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		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	0.120738	12,370,078	0	0	1,493,538	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.165910	10,917	0	0	1,811	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213902	1,628,495	0	0	348,338	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.175371	761,960	0	0	133,626	54.02
57.00	05700	CT SCAN	0.187979	2,082,913	0	0	391,544	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.477761	762,771	0	0	364,422	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.117193	5,412,737	0	0	634,335	60.00
65.00	06500	RESPIRATORY THERAPY	0.478407	411,356	0	0	196,796	65.00
66.00	06600	PHYSICAL THERAPY	0.362005	64,878	0	0	23,486	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.330243	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048081	1,049,156	0	0	50,444	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.113825	110,971	0	0	12,631	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.154058	1,710,619	0	0	263,535	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307130	702,747	0	0	215,835	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304444	2,919,667	0	5,924	888,875	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.229642	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0.136534	4,405,641	0	0	601,520	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.110493	7,853,233	0	0	867,727	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.377256	2,080,131	0	0	784,742	92.00
200.00		Subtotal (see instructions)		44,338,270	0	5,924	7,273,205	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		44,338,270	0	5,924	7,273,205	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 10:58 am

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03480	ONCOLOGY	0	0		54.01
54.02	05402	ULTRASOUND	0	0		54.02
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
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 PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,804		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03330	ENDOSCOPY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	1,804		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,804		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 10:58 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.120738	0	8,595,301	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.165910	0	124,754	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213902	0	1,219,334	0	0	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.175371	0	243,612	0	0	54.02
57.00	05700	CT SCAN	0.187979	0	599,691	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.477761	0	261,757	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.117193	0	2,747,696	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.478407	0	259,185	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.362005	0	97,885	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.330243	0	2,440	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048081	0	168,084	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.113825	0	44,954	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.154058	0	1,986,709	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307130	0	547,211	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304444	0	964,298	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.229642	0	8,855,689	0	0	75.00
76.00	03330	ENDOSCOPY	0.136534	0	2,677,581	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.110493	0	5,383,703	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.377256	0	721,633	0	0	92.00
200.00		Subtotal (see instructions)		0	35,501,517	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	35,501,517	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 10:58 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,037,779	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,698	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	260,818	0		54.00
54.01	03480	ONCOLOGY	0	0		54.01
54.02	05402	ULTRASOUND	42,722	0		54.02
57.00	05700	CT SCAN	112,729	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	125,057	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	322,011	0		60.00
65.00	06500	RESPIRATORY THERAPY	123,996	0		65.00
66.00	06600	PHYSICAL THERAPY	35,435	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	806	0		68.00
69.00	06900	ELECTROCARDIOLOGY	8,082	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,117	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	306,068	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	168,065	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	293,575	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,033,638	0		75.00
76.00	03330	ENDOSCOPY	365,581	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	594,861	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	272,240	0		92.00
200.00		Subtotal (see instructions)	6,129,278	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,129,278	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 10:58 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)	15,450	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,450	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)	13,240	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,235	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)	23,604,025	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)	23,604,025	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)	23,604,025	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)	1,527.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,470,106	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)	6,470,106	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 10:58 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	3,192,452	794	4,020.72	345	1,387,148	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	NEONATAL INTENSIVE CARE UNIT	3,907,733	2,024	1,930.70	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	8,797,436	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	16,654,690	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)	1,022,712	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	808,926	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,831,638	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	14,823,052	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)	2,210	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,527.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,376,372	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 10:58 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	3,190,016	23,604,025	0.135147	3,376,372	456,307	90.00
91.00	Nursing School cost	0	23,604,025	0.000000	3,376,372	0	91.00
92.00	Allied health cost	0	23,604,025	0.000000	3,376,372	0	92.00
93.00	All other Medical Education	0	23,604,025	0.000000	3,376,372	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 10:58 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)	15,450	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,450	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)	13,240	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)	185	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)	2,892	15.00
16.00	Nursery days (title V or XIX only)	17	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)	23,604,025	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)	23,604,025	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)	23,604,025	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)	1,527.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	282,637	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)	282,637	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 10:58 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)	2,790,579	2,892	964.93	17	16,404	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,192,452	794	4,020.72	49	197,015	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	NEONATAL INTENSIVE CARE UNIT	3,907,733	2,024	1,930.70	234	451,784	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,056,053	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,003,893	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)	2,210	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,527.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,376,372	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 10:58 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	3,190,016	23,604,025	0.135147	3,376,372	456,307	90.00
91.00	Nursing School cost	0	23,604,025	0.000000	3,376,372	0	91.00
92.00	Allied health cost	0	23,604,025	0.000000	3,376,372	0	92.00
93.00	All other Medical Education	0	23,604,025	0.000000	3,376,372	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 10:58 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,720,208		30.00
31.00	03100	INTENSIVE CARE UNIT		4,386,740		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0		35.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.120738	19,332,835	2,334,208	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.165910	2,169	360	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214414	565,558	121,264	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	0.175371	129,771	22,758	54.02
57.00	05700	CT SCAN	0.187979	652,800	122,713	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.477761	65,402	31,247	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.117193	5,255,929	615,958	60.00
65.00	06500	RESPIRATORY THERAPY	0.478407	1,180,814	564,910	65.00
66.00	06600	PHYSICAL THERAPY	0.362005	520,496	188,422	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.330243	36,538	12,066	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048081	494,336	23,768	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.113825	460,822	52,453	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.154058	3,097,995	477,271	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307130	7,035,015	2,160,664	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304444	4,755,885	1,447,901	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.229642	0	0	75.00
76.00	03330	ENDOSCOPY	0.136534	499,768	68,235	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.110493	3,034,511	335,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.377256	577,714	217,946	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		47,698,358	8,797,436	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)		47,698,358		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 10:58 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		3,748,892		30.00
31.00	03100	INTENSIVE CARE UNIT		702,793		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		2,986,024		35.00
43.00	04300	NURSERY		870,282		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.120738	5,686,118	686,531	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.165910	2,904,371	481,864	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213902	236,140	50,511	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	0.175371	39,642	6,952	54.02
57.00	05700	CT SCAN	0.187979	145,704	27,389	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.477761	11,578	5,532	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.117193	1,624,898	190,427	60.00
65.00	06500	RESPIRATORY THERAPY	0.478407	344,423	164,774	65.00
66.00	06600	PHYSICAL THERAPY	0.362005	61,337	22,204	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.330243	4,217	1,393	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048081	85,523	4,112	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.113825	20,548	2,339	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.154058	1,515,092	233,412	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307130	1,599,439	491,236	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304444	2,011,063	612,256	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.229642	0	0	75.00
76.00	03330	ENDOSCOPY	0.136534	123,145	16,813	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.110493	527,705	58,308	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.377256	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		16,940,943	3,056,053	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)		16,940,943		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0157	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/26/2018 10:58 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)	2,608,985	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	9,559,661	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)	337,105	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)	146.95	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 which 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)	2.83	30.00
31.00	Percentage of Medicaid patient days (see instructions)	14.33	31.00
32.00	Sum of lines 30 and 31	17.16	32.00
33.00	Allowable disproportionate share percentage (see instructions)	3.90	33.00
34.00	Disproportionate share adjustment (see instructions)	118,645	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Date/Time Prepared: 11/26/2018 10:58 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)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000062111	0.000090058	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	371,269	609,395	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	93,580	455,794	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	549,374		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)	1,224		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	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	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)	13,173,770		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)		13,173,770	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,082,038	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)		14,255,808	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		14,255,808	61.00
62.00	Deductibles billed to program beneficiaries		1,296,392	62.00
63.00	Coinsurance billed to program beneficiaries		72,281	63.00
64.00	Allowable bad debts (see instructions)		85,894	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		55,831	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		33,577	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		12,942,966	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
70.01	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.01
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)		19,451	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0157	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/26/2018 10:58 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		12,962,417	71.00
71.01	Sequestration adjustment (see instructions)		259,248	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		12,128,318	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)		574,851	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		160,698	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (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: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/26/2018 10:58 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	2,608,985	0	2,608,985		2,608,985	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,559,661	0		9,559,661	9,559,661	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	337,105	0	106,586	230,519	337,105	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	0.0390	0.0390	0.0390	0.0390		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	118,645	0	25,438	93,207	118,645	11.00
11.01	Uncompensated care payments	36.00	549,374	0	0	618,301	618,301	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	13,173,770	0	2,741,009	10,432,761	13,173,770	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	13,173,770	0	2,741,009	10,432,761	13,173,770	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,082,038	0	240,406	841,632	1,082,038	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: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/26/2018 10:58 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	2,981,415	11,274,393	14,255,808	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	990,019	0	211,290	778,729	990,019	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	57,071	0	21,657	35,414	57,071	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	0.0353	0.0353	0.0353	0.0353		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	34,948	0	7,459	27,489	34,948	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,082,038	0	240,406	841,632	1,082,038	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				0.019643	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			58,564		58,564	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: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/26/2018 10:58 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	2,608,985	2,608,985		2,608,985	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,559,661		9,559,661	9,559,661	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	337,105	106,586	230,519	337,105	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	0.0390	0.0390	0.0390		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	118,645	25,438	93,207	118,645	11.00
11.01	Uncompensated care payments	36.00	549,374	93,580	455,794	549,374	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	13,173,770	2,834,589	10,339,181	13,173,770	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	13,173,770	2,834,589	10,339,181	13,173,770	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,082,038	240,406	841,632	1,082,038	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			3,074,995	11,180,813	14,255,808	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/26/2018 10:58 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	990,019	211,290	778,729	990,019	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	57,071	21,657	35,414	57,071	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	0.0353	0.0353	0.0353		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	34,948	7,459	27,489	34,948	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,082,038	240,406	841,632	1,082,038	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	19,451	7,521	11,930	19,451	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	0	0	0	0	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: 15-0157	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/26/2018 10:58 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,804	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,273,205	2.00
3.00	OPPS payments	6,371,807	3.00
4.00	Outlier payment (see instructions)	78,518	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)	1,804	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,924	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)	5,924	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)	5,924	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	4,120	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)	1,804	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)	6,450,325	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,279,446	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)	5,172,683	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)	5,172,683	30.00
31.00	Primary payer payments	4,755	31.00
32.00	Subtotal (line 30 minus line 31)	5,167,928	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)	103,068	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	66,994	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	63,569	36.00
37.00	Subtotal (see instructions)	5,234,922	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-155	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)	5,235,077	40.00
40.01	Sequestration adjustment (see instructions)	104,702	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	5,063,383	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	66,992	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: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/26/2018 10:58 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		12,128,318		5,063,383	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)		12,128,318		5,063,383	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		574,851		66,992	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		12,703,169		5,130,375	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: 15-0157	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/26/2018 10:58 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: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-3 Part VII Date/Time Prepared: 11/26/2018 10:58 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	4,003,893		1.00
2.00	Medical and other services		6,129,278	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	4,003,893	6,129,278	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)	4,003,893	6,129,278	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	8,307,991		8.00
9.00	Ancillary service charges	16,940,943	35,501,517	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)	25,248,934	35,501,517	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)	25,248,934	35,501,517	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	21,245,041	29,372,239	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)	4,003,893	6,129,278	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)	4,003,893	6,129,278	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)	4,003,893	6,129,278	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)	4,003,893	6,129,278	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	4,003,893	6,129,278	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)	4,003,893	6,129,278	40.00
41.00	Interim payments	4,003,893	6,129,278	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/26/2018 10:58 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	5,646,994	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	52,880,257	0	0	0	4.00
5.00	Other receivable	3,859,872	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-22,937,798	0	0	0	6.00
7.00	Inventory	2,535,735	0	0	0	7.00
8.00	Prepaid expenses	452,081	0	0	0	8.00
9.00	Other current assets	232,769	0	0	0	9.00
10.00	Due from other funds	10,669,591	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	53,339,501	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	15,676,014	0	0	0	12.00
13.00	Land improvements	2,487,972	0	0	0	13.00
14.00	Accumulated depreciation	-2,204,077	0	0	0	14.00
15.00	Buildings	82,496,314	0	0	0	15.00
16.00	Accumulated depreciation	-47,739,662	0	0	0	16.00
17.00	Leasehold improvements	2,795,304	0	0	0	17.00
18.00	Accumulated depreciation	-2,385,222	0	0	0	18.00
19.00	Fixed equipment	16,756,962	0	0	0	19.00
20.00	Accumulated depreciation	-5,466,417	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	48,920,653	0	0	0	23.00
24.00	Accumulated depreciation	-36,838,945	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)	74,498,896	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	236,075	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	24,533,197	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	24,533,197	236,075	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	152,371,594	236,075	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,924,092	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,353,466	0	0	0	38.00
39.00	Payroll taxes payable	492,388	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	14,838,316	0	0	0	43.00
44.00	Other current liabilities	5,537,764	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	28,146,026	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	19,669,114	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,669,114	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	47,815,140	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	104,556,454				52.00
53.00	Specific purpose fund		236,075			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)	104,556,454	236,075	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	152,371,594	236,075	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/26/2018 10:58 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		89,825,512		227,015		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		73,342,895				2.00
3.00	Total (sum of line 1 and line 2)		163,168,407		227,015		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	OTHER ACTIVITY	0		7,029		0	5.00
6.00	UNREALIZED GAIN/LOSS TEMP REST HSD	0		2,031		0	6.00
7.00	RESTRICTED INCOME	0		0		0	7.00
8.00	ROUNDING	0		0		0	8.00
9.00	OTHER ADJUSTMENT	1		0		0	9.00
10.00	Total additions (sum of line 4-9)		1		9,060		10.00
11.00	Subtotal (line 3 plus line 10)		163,168,408		236,075		11.00
12.00	TRANSFER TO AFFLIATES	0		0		0	12.00
13.00	OTHER ADJUSTMENT	0		0		0	13.00
14.00	DISTRIBUTIONS	10,535,681		0		0	14.00
15.00	NET ASSET TRANSFER TO FROM ALPHA	48,076,273		0		0	15.00
16.00		0		0		0	16.00
17.00	ROUNDING	0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		58,611,954		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		104,556,454		236,075		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	OTHER ACTIVITY		0				5.00
6.00	UNREALIZED GAIN/LOSS TEMP REST HSD		0				6.00
7.00	RESTRICTED INCOME		0				7.00
8.00	ROUNDING		0				8.00
9.00	OTHER ADJUSTMENT		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	TRANSFER TO AFFLIATES		0				12.00
13.00	OTHER ADJUSTMENT		0				13.00
14.00	DISTRIBUTIONS		0				14.00
15.00	NET ASSET TRANSFER TO FROM ALPHA		0				15.00
16.00			0				16.00
17.00	ROUNDING		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: 15-0157 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/26/2018 10:58 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	46,522,525		46,522,525	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	46,522,525		46,522,525	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,420,676		5,420,676	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	NEONATAL INTENSIVE CARE UNIT	13,864,608		13,864,608	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	19,285,284		19,285,284	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	65,807,809		65,807,809	17.00
18.00	Ancillary services	168,897,299	307,638,518	476,535,817	18.00
19.00	Outpatient services	8,060,680	47,385,349	55,446,029	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL FEES	0	4,834,811	4,834,811	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	242,765,788	359,858,678	602,624,466	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		153,606,373		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)		153,606,373		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0157	Period: From 07/01/2017 To 06/30/2018	Worksheet G-3 Date/Time Prepared: 11/26/2018 10:58 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	602,624,466	1.00
2.00	Less contractual allowances and discounts on patients' accounts	384,502,452	2.00
3.00	Net patient revenues (line 1 minus line 2)	218,122,014	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	153,606,373	4.00
5.00	Net income from service to patients (line 3 minus line 4)	64,515,641	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	494,259	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	291,320	16.00
17.00	Revenue from sale of drugs to other than patients	1,220	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	4,439	21.00
22.00	Rental of hospital space	739,844	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	CONTRACT SERVICE REVENUE	596,801	24.01
24.02	OTHER MISCELLANEOUS RVENUE	711,610	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	INCOME FROM UNCONSOLIDATED ENTITIES	-23,833	24.04
24.05	OTHER NONOPERATING	36,532	24.05
24.06	CONSOLIDATING AMT (BILLING ARRANGE)	1,425,032	24.06
24.07	GOVT CLNC INCENTIVE REV	868	24.07
24.08	STATE PROGRAM REVENUE	0	24.08
24.09	GAIN ON SALE OF PPE	0	24.09
24.10	INTRA/INTERCOMPANY OPERATING REVENUE	4,483,642	24.10
24.11	AUXILIARY/GIFT SHOP INCOME	315,138	24.11
25.00	Total other income (sum of lines 6-24)	9,076,872	25.00
26.00	Total (line 5 plus line 25)	73,592,513	26.00
27.00	LOSS ON UNCONSOLIDATED ENTITIES	-57,509	27.00
27.01	INVESTMENT INCOME NONHSD	37	27.01
27.02	OTHER EXPENSES (SPECIFY)	0	27.02
27.03	DONATIONS	307,090	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	249,618	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	73,342,895	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0157	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/26/2018 10:58 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	990,019	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	57,071	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)	48.71	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)	2.83	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	14.33	8.00
9.00	Sum of lines 7 and 8	17.16	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.53	10.00
11.00	Disproportionate share adjustment (see instructions)	34,948	11.00
12.00	Total prospective capital payments (see instructions)	1,082,038	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