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: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 11:50 am

PART I - COST REPORT STATUS

Provider use only
1. [X] Electronically filed cost report Date: 5/29/2019 Time: 11:50 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by UNION HOSPITAL CLINTON (15-1326) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-360,208	133,299	0	-3,091	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	-20,379	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-380,587	133,299	0	-3,091	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: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 11:50 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 801 SOUTH MAIN STREET	PO Box:			1.00
2.00	City: CLINTON	State: IN	Zip Code: 47842-	County: VERMILLION	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	UNION HOSPITAL CLINTON	151326	45460	1	03/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SWING BEDS	15Z326	45460		03/01/2005	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 11:50 am

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 11:50 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 11:50 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

		1.00	2.00	3.00	
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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 11:50 am

		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

		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:	131,105	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 11:50 am

		1.00	2.00	
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	15H043	140.00

	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: UNION HOSPITAL, INC.	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1606 NORTH SEVENTH ST	PO Box:		142.00
143.00	City: TERRE HAUTE	State: IN	Zip Code: 47804	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)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2018	12/31/2018	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 11:50 am

		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: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 11:50 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)	Y			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/01/2019	Y	04/01/2019	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 11:50 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CAROLYN	CHAPLIN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3177137919	CCHAPLIN@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 11:50 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.	SENIOR 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: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 11:50 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	19	6,935	33,024.00	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)		19	6,935	33,024.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	7,584.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	40,608.00	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)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 11:50 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	887	17	1,376			1.00
2.00	HMO and other (see instructions)	101	90				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	161	0	167			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)	1,048	17	1,543			7.00
8.00	INTENSIVE CARE UNIT	155	0	316			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,203	17	1,859	0.00	117.44	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	117.44	27.00
28.00	Observation Bed Days		128	692			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	Provider CCN: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Prepared: 5/29/2019 11:50 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	390	7	630	1.00
2.00	HMO and other (see instructions)			22	37		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	390	7	630	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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/29/2019 11:50 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)	0.320258	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,079,122	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	14,278,953	6.00
7.00	Medicaid cost (line 1 times line 6)	4,572,949	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)	3,493,827	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)	3,493,827	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)	865,606	0	865,606	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	277,217	0	277,217	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)	277,217	0	277,217	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)	4,855,801	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	769,847	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,184,380	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,671,421	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,590,335	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,867,552	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,361,379	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		752,403	752,403	-36,859	715,544	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		410,830	410,830	-1,198	409,632	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	23,874	23,874	0	23,874	5.01
5.02	00550	DATA PROCESSING	0	537,246	537,246	0	537,246	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	47,293	47,293	0	47,293	5.03
5.04	00570	ADMITTING	365,835	81,628	447,463	0	447,463	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	21,473	251,758	273,231	0	273,231	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	649,199	1,727,121	2,376,320	0	2,376,320	5.06
7.00	00700	OPERATION OF PLANT	389,041	801,871	1,190,912	0	1,190,912	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,195	1,195	0	1,195	8.00
9.00	00900	HOUSEKEEPING	221,985	66,830	288,815	0	288,815	9.00
10.00	01000	DIETARY	304,344	229,843	534,187	-428,662	105,525	10.00
11.00	01100	CAFETERIA	0	0	0	428,662	428,662	11.00
13.00	01300	NURSING ADMINISTRATION	500,440	90,202	590,642	0	590,642	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	143,586	83,205	226,791	0	226,791	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	945,025	556,272	1,501,297	0	1,501,297	30.00
31.00	03100	INTENSIVE CARE UNIT	631,815	279,543	911,358	0	911,358	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	317,107	426,354	743,461	39,784	783,245	50.00
51.00	05100	RECOVERY ROOM	44,060	4,445	48,505	0	48,505	51.00
51.01	05101	O/P TREATMENT ROOM	101,162	27,515	128,677	0	128,677	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	688,795	715,362	1,404,157	0	1,404,157	54.00
56.00	05600	RADIOISOTOPE	0	89,292	89,292	0	89,292	56.00
60.00	06000	LABORATORY	0	777,624	777,624	0	777,624	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	46,291	46,291	0	46,291	62.00
65.00	06500	RESPIRATORY THERAPY	401,917	92,944	494,861	11,006	505,867	65.00
66.00	06600	PHYSICAL THERAPY	0	1,286,529	1,286,529	0	1,286,529	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,053	8,053	0	8,053	67.00
68.00	06800	SPEECH PATHOLOGY	0	35,217	35,217	0	35,217	68.00
69.00	06900	ELECTROCARDIOLOGY	25,826	331,375	357,201	0	357,201	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	66,548	66,548	-62,795	3,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	275,382	739,891	1,015,273	0	1,015,273	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,082,822	2,298,917	3,381,739	12,005	3,393,744	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)	7,109,814	12,887,471	19,997,285	-38,057	19,959,228	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	12,153	12,153	0	12,153	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	38,057	38,057	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	7,109,814	12,899,624	20,009,438	0	20,009,438	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,050,285	1,765,829	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	409,632	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,048,662	1,048,662	4.00
5.01	00540	NONPATIENT TELEPHONES	29,272	53,146	5.01
5.02	00550	DATA PROCESSING	1,843,505	2,380,751	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	77,388	124,681	5.03
5.04	00570	ADMITTING	0	447,463	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	284,958	558,189	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	-520,701	1,855,619	5.06
7.00	00700	OPERATION OF PLANT	466,338	1,657,250	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,195	8.00
9.00	00900	HOUSEKEEPING	27,551	316,366	9.00
10.00	01000	DIETARY	11,155	116,680	10.00
11.00	01100	CAFETERIA	-110,852	317,810	11.00
13.00	01300	NURSING ADMINISTRATION	71,539	662,181	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,236	235,027	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-485,340	1,015,957	30.00
31.00	03100	INTENSIVE CARE UNIT	0	911,358	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-36,073	747,172	50.00
51.00	05100	RECOVERY ROOM	231	48,736	51.00
51.01	05101	O/P TREATMENT ROOM	0	128,677	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,059	1,408,216	54.00
56.00	05600	RADIOISOTOPE	0	89,292	56.00
60.00	06000	LABORATORY	0	777,624	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	46,291	62.00
65.00	06500	RESPIRATORY THERAPY	0	505,867	65.00
66.00	06600	PHYSICAL THERAPY	-712,012	574,517	66.00
67.00	06700	OCCUPATIONAL THERAPY	138,558	146,611	67.00
68.00	06800	SPEECH PATHOLOGY	-11,190	24,027	68.00
69.00	06900	ELECTROCARDIOLOGY	5,039	362,240	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,347	1,052,620	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	3,393,744	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)	3,227,955	23,187,183	118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PHYSICIAN PRACTICES	0	12,153	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	38,057	194.01
194.02	07952	VPCHC	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	3,227,955	23,237,393	200.00

RECLASSIFICATIONS

Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 11:50 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	244,223	184,439	1.00
	0		244,223	184,439	
	B - DEPRECIATION RECLASS				
1.00	MEDICAL OFFICE BUILDING	194.01	0	38,057	1.00
2.00		0.00	0	0	2.00
	0		0	38,057	
	C - CENTRAL SUPPLIES RECLASS				
1.00	OPERATING ROOM	50.00	0	39,784	1.00
2.00	RESPIRATORY THERAPY	65.00	0	11,006	2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,345	3.00
4.00	EMERGENCY	91.00	0	12,005	4.00
	0		0	68,140	
500.00	Grand Total: Increases		244,223	290,636	500.00

RECLASSIFICATIONS | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 11:50 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA RECLASS					
1.00	DIETARY	10.00	244,223	184,439	0	1.00
	0		244,223	184,439		
	B - DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	36,859	9	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,198	9	2.00
	0		0	38,057		
	C - CENTRAL SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	68,140	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	0		0	68,140		
500.00	Grand Total: Decreases		244,223	290,636		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I Date/Time Prepared: 5/29/2019 11:50 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	339,822	0	0	0	0	1.00
2.00	Land Improvements	269,938	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,779,148	0	0	0	0	3.00
4.00	Building Improvements	1,645,471	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,839,092	133,126	0	133,126	11,739	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,873,471	133,126	0	133,126	11,739	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	20,873,471	133,126	0	133,126	11,739	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	339,822	0	1.00
2.00	Land Improvements	269,938	0	2.00
3.00	Buildings and Fixtures	11,779,148	0	3.00
4.00	Building Improvements	1,645,471	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	6,960,479	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,994,858	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	20,994,858	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2019 11:50 am

	Cost Center Description	SUMMARY OF CAPITAL Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	751,700	0	703	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	410,830	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,162,530	0	703	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	752,403	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	410,830	2.00
3.00	Total (sum of lines 1-2)	0	1,163,233	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2019 11:50 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	14,034,379	0	14,034,379	0.668467	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	6,960,479	0	6,960,479	0.331533	0	2.00
3.00	Total (sum of lines 1-2)	20,994,858	0	20,994,858	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,765,829	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	409,632	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,175,461	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,765,829	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	409,632	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,175,461	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 11:50 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-703	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-598,266			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	5,526,404			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 11:50 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-1,009	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	CHART FEE REVENUE	B	-218	MEDICAL RECORDS & LIBRARY	16.00	0	33.00
33.01	MISCELLANEOUS REVENUE	B	-5,557	ADMINISTRATIVE AND GENERAL	5.06	0	33.01
33.02	CAFETERIA REVENUE	B	-165,654	CAFETERIA	11.00	0	33.02
33.03	CATERING REVENUE	B	-2,141	CAFETERIA	11.00	0	33.03
33.04	ADVERTISING	A	-2,209	ADMINISTRATIVE AND GENERAL	5.06	0	33.04
33.05	VPCHC	B	-5,386	HOUSEKEEPING	9.00	0	33.05
35.00	RENTAL REVENUE	B	-153,966	OPERATION OF PLANT	7.00	0	35.00
36.00	HAF	A	-1,323,340	ADMINISTRATIVE AND GENERAL	5.06	0	36.00
39.00	PHYSICIAN RECRUITMENT	A	-40,000	ADMINISTRATIVE AND GENERAL	5.06	0	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		3,227,955				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: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/29/2019 11:50 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	1,051,997	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,048,662	0	2.00
3.00	5.01	NONPATIENT TELEPHONES	HOME OFFICE	29,272	0	3.00
4.00	5.02	DATA PROCESSING	HOME OFFICE	1,843,505	0	4.00
4.01	5.03	PURCHASING RECEIVING AND STO	HOME OFFICE	77,388	0	4.01
4.02	5.05	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	284,958	0	4.02
4.03	5.06	ADMINISTRATIVE AND GENERAL	HOME OFFICE	850,405	0	4.03
4.04	7.00	OPERATION OF PLANT	HOME OFFICE	620,304	0	4.04
4.05	9.00	HOUSEKEEPING	HOME OFFICE	32,937	0	4.05
4.06	10.00	DIETARY	HOME OFFICE	11,155	0	4.06
4.07	11.00	CAFETERIA	HOME OFFICE	56,943	0	4.07
4.08	13.00	NURSING ADMINISTRATION	HOME OFFICE	71,539	0	4.08
4.09	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	8,454	0	4.09
4.10	50.00	OPERATING ROOM	HOME OFFICE	3,667	0	4.10
4.11	51.00	RECOVERY ROOM	HOME OFFICE	231	0	4.11
4.12	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	77,245	0	4.12
4.13	66.00	PHYSICAL THERAPY	HOME OFFICE	4,185	0	4.13
4.14	67.00	OCCUPATIONAL THERAPY	HOME OFFICE	1,226	0	4.14
4.15	68.00	SPEECH PATHOLOGY	HOME OFFICE	187	0	4.15
4.16	69.00	ELECTROCARDIOLOGY	HOME OFFICE	5,039	0	4.16
4.17	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	37,347	0	4.17
4.18	66.00	PHYSICAL THERAPY	THERAPY	468,659	1,184,856	4.18
4.19	67.00	OCCUPATIONAL THERAPY	THERAPY	137,332	0	4.19
4.20	68.00	SPEECH PATHOLOGY	THERAPY	20,956	32,333	4.20
5.00	0		0	6,743,593	1,217,189	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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	G		0.00	UNION HOSPITAL	100.00	6.00
7.00	G		0.00	UNION THERAPY	51.00	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:	OTHER				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: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/29/2019 11:50 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	1,051,997	9	1.00
2.00	1,048,662	0	2.00
3.00	29,272	0	3.00
4.00	1,843,505	0	4.00
4.01	77,388	0	4.01
4.02	284,958	0	4.02
4.03	850,405	0	4.03
4.04	620,304	0	4.04
4.05	32,937	0	4.05
4.06	11,155	0	4.06
4.07	56,943	0	4.07
4.08	71,539	0	4.08
4.09	8,454	0	4.09
4.10	3,667	0	4.10
4.11	231	0	4.11
4.12	77,245	0	4.12
4.13	4,185	0	4.13
4.14	1,226	0	4.14
4.15	187	0	4.15
4.16	5,039	0	4.16
4.17	37,347	0	4.17
4.18	-716,197	0	4.18
4.19	137,332	0	4.19
4.20	-11,377	0	4.20
5.00	5,526,404		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.

	Type of Business	
6.00	HOME OFFICE	6.00
7.00	THERAPY	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: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 Date/Time Prepared: 5/29/2019 11:50 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	485,340	485,340	0	0	0	1.00
2.00	50.00	OPERATING ROOM	39,740	39,740	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	73,186	73,186	0	0	0	3.00
4.00	91.00	EMERGENCY	2,037,726	0	2,037,726	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,635,992	598,266	2,037,726		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	485,340	1.00
2.00	50.00	OPERATING ROOM	0	0	0	39,740	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	73,186	3.00
4.00	91.00	EMERGENCY	0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	598,266	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,765,829	1,765,829				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	409,632		409,632			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,048,662	0	0	1,048,662		4.00
5.01	00540	NONPATIENT TELEPHONES	53,146	2,361	19,899	0	75,406	5.01
5.02	00550	DATA PROCESSING	2,380,751	4,608	236,413	0	1,187	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	124,681	17,955	0	0	594	5.03
5.04	00570	ADMITTING	447,463	11,440	278	53,959	2,078	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	558,189	6,764	0	3,167	1,484	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	1,855,619	33,458	6,037	95,754	4,156	5.06
7.00	00700	OPERATION OF PLANT	1,657,250	487,704	6,457	57,382	6,531	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,195	9,397	245	0	0	8.00
9.00	00900	HOUSEKEEPING	316,366	8,898	3,007	32,742	297	9.00
10.00	01000	DIETARY	116,680	20,270	1,992	8,868	297	10.00
11.00	01100	CAFETERIA	317,810	81,057	7,967	36,022	1,781	11.00
13.00	01300	NURSING ADMINISTRATION	662,181	31,370	209	73,812	1,187	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	235,027	19,861	58	21,178	2,375	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,015,957	317,511	22,958	139,386	20,191	30.00
31.00	03100	INTENSIVE CARE UNIT	911,358	9,307	6,236	93,190	1,781	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	747,172	67,756	40,922	46,772	1,781	50.00
51.00	05100	RECOVERY ROOM	48,736	6,832	4,186	6,499	594	51.00
51.01	05101	O/P TREATMENT ROOM	128,677	36,500	2,386	14,921	3,562	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,408,216	129,497	15,642	101,594	4,453	54.00
56.00	05600	RADIOISOTOPE	89,292	5,970	212	0	297	56.00
60.00	06000	LABORATORY	777,624	38,838	0	0	1,781	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	46,291	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	505,867	23,244	11,431	59,281	1,781	65.00
66.00	06600	PHYSICAL THERAPY	574,517	76,699	1,182	0	2,969	66.00
67.00	06700	OCCUPATIONAL THERAPY	146,611	64,510	0	0	2,078	67.00
68.00	06800	SPEECH PATHOLOGY	24,027	8,716	0	0	594	68.00
69.00	06900	ELECTROCARDIOLOGY	362,240	9,511	463	3,809	1,187	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,753	23,062	0	0	297	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,052,620	23,017	2,230	40,617	1,781	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,393,744	189,716	19,222	159,709	8,312	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)	23,187,183	1,765,829	409,632	1,048,662	75,406	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	12,153	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	38,057	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	23,237,393	1,765,829	409,632	1,048,662	75,406	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	2,622,959					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	143,230				5.03
5.04	00570	ADMITTING	121,060	2,280	638,558			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	40,353	0	0	609,957		5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	262,296	68	0	0	2,257,388	5.06
7.00	00700	OPERATION OF PLANT	524,591	30	0	0	2,739,945	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	36	0	0	10,873	8.00
9.00	00900	HOUSEKEEPING	20,177	11,825	0	0	393,312	9.00
10.00	01000	DIETARY	20,177	16	0	0	168,300	10.00
11.00	01100	CAFETERIA	40,353	64	0	0	485,054	11.00
13.00	01300	NURSING ADMINISTRATION	80,706	0	0	0	849,465	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	161,413	19	0	0	439,931	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	221,943	18,776	209,393	30,645	1,996,760	30.00
31.00	03100	INTENSIVE CARE UNIT	20,177	8,002	58,243	8,537	1,116,831	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	80,706	42,826	58,107	40,000	1,126,042	50.00
51.00	05100	RECOVERY ROOM	0	0	1,558	2,519	70,924	51.00
51.01	05101	O/P TREATMENT ROOM	20,177	8,925	491	9,240	224,879	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	181,589	11,504	47,834	164,445	2,064,774	54.00
56.00	05600	RADIOISOTOPE	0	224	1,808	4,367	102,170	56.00
60.00	06000	LABORATORY	20,177	0	72,702	74,715	985,837	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	3,750	979	51,020	62.00
65.00	06500	RESPIRATORY THERAPY	40,353	2,610	33,992	7,889	686,448	65.00
66.00	06600	PHYSICAL THERAPY	80,706	300	9,940	22,431	768,744	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,920	6,573	222,692	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	591	1,003	34,931	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4	20,333	29,964	427,511	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,241	193	28,546	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,530	200	73,602	45,439	1,300,036	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	302,649	35,521	42,053	161,018	4,311,944	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)	2,300,133	143,230	638,558	609,957	22,864,357	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	322,826	0	0	0	334,979	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	38,057	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,622,959	143,230	638,558	609,957	23,237,393	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	2,257,388					5.06
7.00	00700	OPERATION OF PLANT	294,810	3,034,755				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,170	23,210	35,253			8.00
9.00	00900	HOUSEKEEPING	42,319	21,977	3,197	460,805		9.00
10.00	01000	DIETARY	18,109	50,064	136	7,717	244,326	10.00
11.00	01100	CAFETERIA	52,190	200,202	545	30,859	0	11.00
13.00	01300	NURSING ADMINISTRATION	91,400	77,479	0	11,942	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	47,335	49,055	0	7,561	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	214,845	784,211	7,561	120,877	182,884	30.00
31.00	03100	INTENSIVE CARE UNIT	120,168	22,986	4,584	3,543	37,449	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	121,159	167,349	1,710	25,795	0	50.00
51.00	05100	RECOVERY ROOM	7,631	16,875	0	2,601	0	51.00
51.01	05101	O/P TREATMENT ROOM	24,196	90,150	0	13,895	23,993	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	222,163	319,840	2,989	49,299	0	54.00
56.00	05600	RADIOISOTOPE	10,993	14,745	0	2,273	0	56.00
60.00	06000	LABORATORY	106,073	95,924	0	14,786	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,490	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	73,860	57,409	265	8,849	0	65.00
66.00	06600	PHYSICAL THERAPY	82,715	189,437	3,378	29,199	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,961	159,332	0	24,559	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,758	21,528	0	3,318	0	68.00
69.00	06900	ELECTROCARDIOLOGY	45,999	23,490	770	3,621	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,071	56,960	0	8,780	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	139,880	56,848	0	8,762	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	463,955	468,576	10,118	72,225	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)	2,217,250	2,967,647	35,253	450,461	244,326	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	36,043	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	4,095	67,108	0	10,344	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
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)	2,257,388	3,034,755	35,253	460,805	244,326	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL						5.06
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	768,850					11.00
13.00	01300	NURSING ADMINISTRATION	56,860	1,087,146				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,829	0	575,711			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	157,190	408,172	28,924	3,901,424	0	30.00
31.00	03100	INTENSIVE CARE UNIT	82,097	213,235	8,058	1,608,951	0	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	44,293	0	37,755	1,524,103	0	50.00
51.00	05100	RECOVERY ROOM	6,902	0	2,377	107,310	0	51.00
51.01	05101	O/P TREATMENT ROOM	18,335	45,622	8,721	449,791	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,836	0	155,209	2,925,110	0	54.00
56.00	05600	RADIOISOTOPE	0	0	4,122	134,303	0	56.00
60.00	06000	LABORATORY	0	0	70,521	1,273,141	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	924	57,434	0	62.00
65.00	06500	RESPIRATORY THERAPY	58,096	0	7,446	892,373	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	21,172	1,094,645	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	6,204	436,748	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	947	64,482	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,605	0	28,282	533,278	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	182	97,539	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	36,980	0	42,888	1,585,394	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	161,827	420,117	151,979	6,060,741	0	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)	768,850	1,087,146	575,711	22,746,767	0	118.00
	NONREIMBURSABLE COST CENTERS							
194.00	07950	PHYSICIAN PRACTICES	0	0	0	371,022	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	119,604	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	768,850	1,087,146	575,711	23,237,393	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540	NONPATIENT TELEPHONES		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00560	PURCHASING RECEIVING AND STORES		5.03
5.04	00570	ADMITTING		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00591	ADMINISTRATIVE AND GENERAL		5.06
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
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	3,901,424	30.00
31.00	03100	INTENSIVE CARE UNIT	1,608,951	31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	1,524,103	50.00
51.00	05100	RECOVERY ROOM	107,310	51.00
51.01	05101	O/P TREATMENT ROOM	449,791	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,925,110	54.00
56.00	05600	RADIOISOTOPE	134,303	56.00
60.00	06000	LABORATORY	1,273,141	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	57,434	62.00
65.00	06500	RESPIRATORY THERAPY	892,373	65.00
66.00	06600	PHYSICAL THERAPY	1,094,645	66.00
67.00	06700	OCCUPATIONAL THERAPY	436,748	67.00
68.00	06800	SPEECH PATHOLOGY	64,482	68.00
69.00	06900	ELECTROCARDIOLOGY	533,278	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,539	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,585,394	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	6,060,741	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)	22,746,767	118.00
		NONREIMBURSABLE COST CENTERS		
194.00	07950	PHYSICIAN PRACTICES	371,022	194.00
194.01	07951	MEDICAL OFFICE BUILDING	119,604	194.01
194.02	07952	VPCHC	0	194.02
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	23,237,393	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	2,361	19,899	22,260	0	5.01
5.02	00550	DATA PROCESSING	0	4,608	236,413	241,021	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	17,955	0	17,955	0	5.03
5.04	00570	ADMITTING	0	11,440	278	11,718	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	6,764	0	6,764	0	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	0	33,458	6,037	39,495	0	5.06
7.00	00700	OPERATION OF PLANT	0	487,704	6,457	494,161	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,397	245	9,642	0	8.00
9.00	00900	HOUSEKEEPING	0	8,898	3,007	11,905	0	9.00
10.00	01000	DIETARY	0	20,270	1,992	22,262	0	10.00
11.00	01100	CAFETERIA	0	81,057	7,967	89,024	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	31,370	209	31,579	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,861	58	19,919	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	317,511	22,958	340,469	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,307	6,236	15,543	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	67,756	40,922	108,678	0	50.00
51.00	05100	RECOVERY ROOM	0	6,832	4,186	11,018	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	36,500	2,386	38,886	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	129,497	15,642	145,139	0	54.00
56.00	05600	RADIOISOTOPE	0	5,970	212	6,182	0	56.00
60.00	06000	LABORATORY	0	38,838	0	38,838	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	23,244	11,431	34,675	0	65.00
66.00	06600	PHYSICAL THERAPY	0	76,699	1,182	77,881	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	64,510	0	64,510	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,716	0	8,716	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,511	463	9,974	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,062	0	23,062	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	23,017	2,230	25,247	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	189,716	19,222	208,938	0	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)	0	1,765,829	409,632	2,175,461	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,765,829	409,632	2,175,461	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	22,260					5.01
5.02	00550	DATA PROCESSING	351	241,372				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	175	0	18,130			5.03
5.04	00570	ADMITTING	613	11,140	289	23,760		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	438	3,713	0	0	10,915	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	1,227	24,137	9	0	0	5.06
7.00	00700	OPERATION OF PLANT	1,928	48,274	4	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	5	0	0	8.00
9.00	00900	HOUSEKEEPING	88	1,857	1,497	0	0	9.00
10.00	01000	DIETARY	88	1,857	2	0	0	10.00
11.00	01100	CAFETERIA	526	3,713	8	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	351	7,427	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	701	14,854	2	0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,957	20,424	2,377	7,790	550	30.00
31.00	03100	INTENSIVE CARE UNIT	526	1,857	1,013	2,167	153	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	526	7,427	5,420	2,162	717	50.00
51.00	05100	RECOVERY ROOM	175	0	0	58	45	51.00
51.01	05101	O/P TREATMENT ROOM	1,052	1,857	1,130	18	166	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,315	16,710	1,456	1,780	2,925	54.00
56.00	05600	RADIOISOTOPE	88	0	28	67	78	56.00
60.00	06000	LABORATORY	526	1,857	0	2,705	1,340	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	140	18	62.00
65.00	06500	RESPIRATORY THERAPY	526	3,713	330	1,265	142	65.00
66.00	06600	PHYSICAL THERAPY	876	7,427	38	370	402	66.00
67.00	06700	OCCUPATIONAL THERAPY	613	0	0	109	118	67.00
68.00	06800	SPEECH PATHOLOGY	175	0	0	22	18	68.00
69.00	06900	ELECTROCARDIOLOGY	351	0	1	757	537	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	88	0	0	46	3	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	526	5,570	25	2,739	815	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,454	27,851	4,496	1,565	2,888	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)	22,260	211,665	18,130	23,760	10,915	118.00
	NONREIMBURSABLE COST CENTERS							
194.00	07950	PHYSICIAN PRACTICES	0	29,707	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
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)	22,260	241,372	18,130	23,760	10,915	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	64,868					5.06
7.00	00700	OPERATION OF PLANT	8,472	552,839				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34	4,228	13,909			8.00
9.00	00900	HOUSEKEEPING	1,216	4,003	1,261	21,827		9.00
10.00	01000	DIETARY	520	9,120	54	366	34,269	10.00
11.00	01100	CAFETERIA	1,500	36,471	215	1,462	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,627	14,114	0	566	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,360	8,936	0	358	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,174	142,862	2,983	5,725	25,651	30.00
31.00	03100	INTENSIVE CARE UNIT	3,453	4,187	1,808	168	5,253	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,482	30,486	675	1,222	0	50.00
51.00	05100	RECOVERY ROOM	219	3,074	0	123	0	51.00
51.01	05101	O/P TREATMENT ROOM	695	16,422	0	658	3,365	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,384	58,265	1,179	2,335	0	54.00
56.00	05600	RADIOISOTOPE	316	2,686	0	108	0	56.00
60.00	06000	LABORATORY	3,048	17,474	0	700	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	158	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,122	10,458	105	419	0	65.00
66.00	06600	PHYSICAL THERAPY	2,377	34,510	1,333	1,383	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	689	29,025	0	1,163	0	67.00
68.00	06800	SPEECH PATHOLOGY	108	3,922	0	157	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,322	4,279	304	172	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	88	10,376	0	416	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	4,020	10,356	0	415	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	13,330	85,360	3,992	3,421	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)	63,714	540,614	13,909	21,337	34,269	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	1,036	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	118	12,225	0	490	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
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)	64,868	552,839	13,909	21,827	34,269	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL						5.06
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	132,919					11.00
13.00	01300	NURSING ADMINISTRATION	9,830	66,494				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,503	0	51,633			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,175	24,965	2,595	615,697	0	30.00
31.00	03100	INTENSIVE CARE UNIT	14,193	13,042	723	64,086	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,657	0	3,387	171,839	0	50.00
51.00	05100	RECOVERY ROOM	1,193	0	213	16,118	0	51.00
51.01	05101	O/P TREATMENT ROOM	3,170	2,790	782	70,991	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,161	0	13,911	270,560	0	54.00
56.00	05600	RADIOISOTOPE	0	0	370	9,923	0	56.00
60.00	06000	LABORATORY	0	0	6,326	72,814	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	83	399	0	62.00
65.00	06500	RESPIRATORY THERAPY	10,044	0	668	64,467	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,899	128,496	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	557	96,784	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	85	13,203	0	68.00
69.00	06900	ELECTROCARDIOLOGY	623	0	2,537	20,857	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	16	34,095	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	6,393	0	3,847	59,953	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	27,977	25,697	13,634	421,603	0	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)	132,919	66,494	51,633	2,131,885	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	30,743	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	12,833	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	132,919	66,494	51,633	2,175,461	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	Total	
			26.00	
	GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540	NONPATIENT TELEPHONES		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00560	PURCHASING RECEIVING AND STORES		5.03
5.04	00570	ADMITTING		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00591	ADMINISTRATIVE AND GENERAL		5.06
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
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	615,697	30.00
31.00	03100	INTENSIVE CARE UNIT	64,086	31.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	171,839	50.00
51.00	05100	RECOVERY ROOM	16,118	51.00
51.01	05101	O/P TREATMENT ROOM	70,991	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	270,560	54.00
56.00	05600	RADIOISOTOPE	9,923	56.00
60.00	06000	LABORATORY	72,814	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	399	62.00
65.00	06500	RESPIRATORY THERAPY	64,467	65.00
66.00	06600	PHYSICAL THERAPY	128,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	96,784	67.00
68.00	06800	SPEECH PATHOLOGY	13,203	68.00
69.00	06900	ELECTROCARDIOLOGY	20,857	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,095	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,953	73.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	421,603	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)	2,131,885	118.00
	NONREIMBURSABLE COST CENTERS			
194.00	07950	PHYSICIAN PRACTICES	30,743	194.00
194.01	07951	MEDICAL OFFICE BUILDING	12,833	194.01
194.02	07952	VPCHC	0	194.02
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,175,461	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQ FT)	NEW MVBLE EQUIP (EQUIP DEPRN)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	DATA PROCESSING (DEVICES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	77,794					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		400,975				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,109,814			4.00
5.01	00540	NONPATIENT TELEPHONES	104	19,478	0	254		5.01
5.02	00550	DATA PROCESSING	203	231,416	0	4	130	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	791	0	0	2	0	5.03
5.04	00570	ADMITTING	504	272	365,835	7	6	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	298	0	21,473	5	2	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	1,474	5,909	649,199	14	13	5.06
7.00	00700	OPERATION OF PLANT	21,486	6,321	389,041	22	26	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	240	0	0	0	8.00
9.00	00900	HOUSEKEEPING	392	2,943	221,985	1	1	9.00
10.00	01000	DIETARY	893	1,950	60,121	1	1	10.00
11.00	01100	CAFETERIA	3,571	7,799	244,223	6	2	11.00
13.00	01300	NURSING ADMINISTRATION	1,382	205	500,440	4	4	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	875	57	143,586	8	8	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,988	22,473	945,025	68	11	30.00
31.00	03100	INTENSIVE CARE UNIT	410	6,104	631,815	6	1	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,985	40,057	317,107	6	4	50.00
51.00	05100	RECOVERY ROOM	301	4,098	44,060	2	0	51.00
51.01	05101	O/P TREATMENT ROOM	1,608	2,336	101,162	12	1	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,705	15,311	688,795	15	9	54.00
56.00	05600	RADIOISOTOPE	263	208	0	1	0	56.00
60.00	06000	LABORATORY	1,711	0	0	6	1	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,024	11,189	401,917	6	2	65.00
66.00	06600	PHYSICAL THERAPY	3,379	1,157	0	10	4	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,842	0	0	7	0	67.00
68.00	06800	SPEECH PATHOLOGY	384	0	0	2	0	68.00
69.00	06900	ELECTROCARDIOLOGY	419	453	25,826	4	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,016	0	0	1	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	1,014	2,183	275,382	6	3	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,358	18,816	1,082,822	28	15	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)	77,794	400,975	7,109,814	254	114	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	16	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,765,829	409,632	1,048,662	75,406	2,622,959	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.698781	1.021590	0.147495	296.874016	20,176.607692	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	22,260	241,372	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	87.637795	1,856.707692	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: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	PURCHASING RECEIVING AND STORES (REQUISITIO)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	288,645					5.03
5.04	00570	ADMITTING	4,595	8,067,938				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	71,041,240			5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	138	0	0	-2,257,388	20,980,005	5.06
7.00	00700	OPERATION OF PLANT	60	0	0	0	2,739,945	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	72	0	0	0	10,873	8.00
9.00	00900	HOUSEKEEPING	23,831	0	0	0	393,312	9.00
10.00	01000	DIETARY	32	0	0	0	168,300	10.00
11.00	01100	CAFETERIA	129	0	0	0	485,054	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	849,465	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38	0	0	0	439,931	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,839	2,645,621	3,569,159	0	1,996,760	30.00
31.00	03100	INTENSIVE CARE UNIT	16,127	735,880	994,292	0	1,116,831	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	86,302	734,158	4,658,763	0	1,126,042	50.00
51.00	05100	RECOVERY ROOM	0	19,683	293,357	0	70,924	51.00
51.01	05101	O/P TREATMENT ROOM	17,986	6,206	1,076,191	0	224,879	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,184	604,363	19,153,093	0	2,064,774	54.00
56.00	05600	RADIOISOTOPE	452	22,839	508,622	0	102,170	56.00
60.00	06000	LABORATORY	0	918,553	8,702,002	0	985,837	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	47,385	114,018	0	51,020	62.00
65.00	06500	RESPIRATORY THERAPY	5,260	429,470	918,856	0	686,448	65.00
66.00	06600	PHYSICAL THERAPY	605	125,582	2,612,517	0	768,744	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	36,891	765,550	0	222,692	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,469	116,818	0	34,931	68.00
69.00	06900	ELECTROCARDIOLOGY	8	256,903	3,489,844	0	427,511	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,683	22,429	0	28,546	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	404	929,929	5,292,184	0	1,300,036	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	71,583	531,323	18,753,545	0	4,311,944	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)	288,645	8,067,938	71,041,240	-2,257,388	20,606,969	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	334,979	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	38,057	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
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)	143,230	638,558	609,957		2,257,388	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.496215	0.079148	0.008586		0.107597	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,130	23,760	10,915		64,868	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.062811	0.002945	0.000154		0.003092	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: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	OPERATION OF PLANT (SQ FT)	LAUNDRY & LINEN SERVICE (LINEN)	HOUSEKEEPING (NUMBER HOUSED)	DIETARY (DIETARY)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT	54,131					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	62,390				8.00
9.00	00900	HOUSEKEEPING	392	5,658	53,325			9.00
10.00	01000	DIETARY	893	241	893	5,774		10.00
11.00	01100	CAFETERIA	3,571	964	3,571	0	7,464	11.00
13.00	01300	NURSING ADMINISTRATION	1,382	0	1,382	0	552	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	875	0	875	0	309	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,988	13,381	13,988	4,322	1,526	30.00
31.00	03100	INTENSIVE CARE UNIT	410	8,112	410	885	797	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,985	3,027	2,985	0	430	50.00
51.00	05100	RECOVERY ROOM	301	0	301	0	67	51.00
51.01	05101	O/P TREATMENT ROOM	1,608	0	1,608	567	178	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,705	5,289	5,705	0	1,076	54.00
56.00	05600	RADIOISOTOPE	263	0	263	0	0	56.00
60.00	06000	LABORATORY	1,711	0	1,711	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,024	469	1,024	0	564	65.00
66.00	06600	PHYSICAL THERAPY	3,379	5,978	3,379	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,842	0	2,842	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	384	0	384	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	419	1,363	419	0	35	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,016	0	1,016	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	1,014	0	1,014	0	359	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,358	17,908	8,358	0	1,571	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)	52,934	62,390	52,128	5,774	7,464	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	1,197	0	1,197	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,034,755	35,253	460,805	244,326	768,850	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	56.063162	0.565042	8.641444	42.314860	103.007771	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	552,839	13,909	21,827	34,269	132,919	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.212983	0.222936	0.409320	5.935054	17.808012	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: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	NURSING ADMINISTRATION (TIME SPENT)	MEDICAL RECORDS & LIBRARY (ASSIGNED TIME)	
			13.00	16.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00560	PURCHASING RECEIVING AND STORES			5.03
5.04	00570	ADMITTING			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.05
5.06	00591	ADMINISTRATIVE AND GENERAL			5.06
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	84,546		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	71,041,240	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	31,743	3,569,159	30.00
31.00	03100	INTENSIVE CARE UNIT	16,583	994,292	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	4,658,763	50.00
51.00	05100	RECOVERY ROOM	0	293,357	51.00
51.01	05101	O/P TREATMENT ROOM	3,548	1,076,191	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,153,093	54.00
56.00	05600	RADIOISOTOPE	0	508,622	56.00
60.00	06000	LABORATORY	0	8,702,002	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	114,018	62.00
65.00	06500	RESPIRATORY THERAPY	0	918,856	65.00
66.00	06600	PHYSICAL THERAPY	0	2,612,517	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	765,550	67.00
68.00	06800	SPEECH PATHOLOGY	0	116,818	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,489,844	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,429	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,292,184	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	32,672	18,753,545	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)	84,546	71,041,240	118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PHYSICIAN PRACTICES	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	194.01
194.02	07952	VPCHC	0	0	194.02
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,087,146	575,711	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.858633	0.008104	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	66,494	51,633	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.786483	0.000727	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: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 11:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,901,424		3,901,424	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,608,951		1,608,951	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,524,103		1,524,103	0	0	50.00
51.00	05100	RECOVERY ROOM	107,310		107,310	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	449,791		449,791	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,925,110		2,925,110	0	0	54.00
56.00	05600	RADIOISOTOPE	134,303		134,303	0	0	56.00
60.00	06000	LABORATORY	1,273,141		1,273,141	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	57,434		57,434	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	892,373	0	892,373	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,094,645	0	1,094,645	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	436,748	0	436,748	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	64,482	0	64,482	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	533,278		533,278	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,539		97,539	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,585,394		1,585,394	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	6,060,741		6,060,741	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,207,955		1,207,955		0	92.00
200.00		Subtotal (see instructions)	23,954,722	0	23,954,722	0	0	200.00
201.00		Less Observation Beds	1,207,955		1,207,955		0	201.00
202.00		Total (see instructions)	22,746,767	0	22,746,767	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/29/2019 11:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	2,652,512		2,652,512			30.00
31.00	03100	INTENSIVE CARE UNIT	994,292		994,292			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	734,158	3,924,605	4,658,763	0.327148	0.000000	50.00
51.00	05100	RECOVERY ROOM	13,183	280,174	293,357	0.365800	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	6,206	1,052,280	1,058,486	0.424938	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	604,363	18,548,730	19,153,093	0.152723	0.000000	54.00
56.00	05600	RADIOISOTOPE	22,839	485,783	508,622	0.264053	0.000000	56.00
60.00	06000	LABORATORY	918,553	7,783,449	8,702,002	0.146304	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	47,385	66,633	114,018	0.503727	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	429,470	489,386	918,856	0.971178	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	125,582	2,486,935	2,612,517	0.419000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	36,891	728,660	765,551	0.570502	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	7,469	109,349	116,818	0.551987	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	256,903	3,232,941	3,489,844	0.152809	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,683	6,746	22,429	4.348790	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	929,929	4,362,255	5,292,184	0.299573	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	531,323	18,222,222	18,753,545	0.323178	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	919,430	919,430	1.313809	0.000000	92.00
200.00		Subtotal (see instructions)	8,326,741	62,699,578	71,026,319			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,326,741	62,699,578	71,026,319			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 11:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
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
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
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
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: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/29/2019 11:50 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	3,901,424		3,901,424	0	3,901,424	30.00
31.00	03100	INTENSIVE CARE UNIT	1,608,951		1,608,951	0	1,608,951	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,524,103		1,524,103	0	1,524,103	50.00
51.00	05100	RECOVERY ROOM	107,310		107,310	0	107,310	51.00
51.01	05101	O/P TREATMENT ROOM	449,791		449,791	0	449,791	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,925,110		2,925,110	0	2,925,110	54.00
56.00	05600	RADIOISOTOPE	134,303		134,303	0	134,303	56.00
60.00	06000	LABORATORY	1,273,141		1,273,141	0	1,273,141	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	57,434		57,434	0	57,434	62.00
65.00	06500	RESPIRATORY THERAPY	892,373	0	892,373	0	892,373	65.00
66.00	06600	PHYSICAL THERAPY	1,094,645	0	1,094,645	0	1,094,645	66.00
67.00	06700	OCCUPATIONAL THERAPY	436,748	0	436,748	0	436,748	67.00
68.00	06800	SPEECH PATHOLOGY	64,482	0	64,482	0	64,482	68.00
69.00	06900	ELECTROCARDIOLOGY	533,278		533,278	0	533,278	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,539		97,539	0	97,539	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,585,394		1,585,394	0	1,585,394	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	6,060,741		6,060,741	0	6,060,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,207,955		1,207,955		1,207,955	92.00
200.00		Subtotal (see instructions)	23,954,722	0	23,954,722	0	23,954,722	200.00
201.00		Less Observation Beds	1,207,955		1,207,955		1,207,955	201.00
202.00		Total (see instructions)	22,746,767	0	22,746,767	0	22,746,767	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/29/2019 11:50 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	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	2,652,512		2,652,512			30.00
31.00	03100	INTENSIVE CARE UNIT	994,292		994,292			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	734,158	3,924,605	4,658,763	0.327148	0.000000	50.00
51.00	05100	RECOVERY ROOM	13,183	280,174	293,357	0.365800	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	6,206	1,052,280	1,058,486	0.424938	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	604,363	18,548,730	19,153,093	0.152723	0.000000	54.00
56.00	05600	RADIOISOTOPE	22,839	485,783	508,622	0.264053	0.000000	56.00
60.00	06000	LABORATORY	918,553	7,783,449	8,702,002	0.146304	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	47,385	66,633	114,018	0.503727	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	429,470	489,386	918,856	0.971178	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	125,582	2,486,935	2,612,517	0.419000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	36,891	728,660	765,551	0.570502	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	7,469	109,349	116,818	0.551987	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	256,903	3,232,941	3,489,844	0.152809	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,683	6,746	22,429	4.348790	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	929,929	4,362,255	5,292,184	0.299573	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	531,323	18,222,222	18,753,545	0.323178	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	919,430	919,430	1.313809	0.000000	92.00
200.00		Subtotal (see instructions)	8,326,741	62,699,578	71,026,319			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,326,741	62,699,578	71,026,319			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 11:50 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
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
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
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 11:50 am

		Title XVIII		Hospital	Cost	
	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	171,839	4,658,763	0.036885	393,952	14,531	50.00
51.00	05100 RECOVERY ROOM	16,118	293,357	0.054943	12,599	692	51.00
51.01	05101 O/P TREATMENT ROOM	70,991	1,058,486	0.067068	180	12	51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	270,560	19,153,093	0.014126	175,859	2,484	54.00
56.00	05600 RADIOISOTOPE	9,923	508,622	0.019510	12,740	249	56.00
60.00	06000 LABORATORY	72,814	8,702,002	0.008367	412,377	3,450	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	399	114,018	0.003499	31,307	110	62.00
65.00	06500 RESPIRATORY THERAPY	64,467	918,856	0.070160	239,193	16,782	65.00
66.00	06600 PHYSICAL THERAPY	128,496	2,612,517	0.049185	71,655	3,524	66.00
67.00	06700 OCCUPATIONAL THERAPY	96,784	765,551	0.126424	21,437	2,710	67.00
68.00	06800 SPEECH PATHOLOGY	13,203	116,818	0.113022	6,179	698	68.00
69.00	06900 ELECTROCARDIOLOGY	20,857	3,489,844	0.005976	163,483	977	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	34,095	22,429	1.520130	7,449	11,323	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	59,953	5,292,184	0.011329	485,078	5,495	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	421,603	18,753,545	0.022481	3,133	70	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	190,631	919,430	0.207336	0	0	92.00
200.00	Total (lines 50 through 199)	1,642,733	67,379,515		2,036,621	63,107	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 11:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
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
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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1326

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

Worksheet D Part IV Date/Time Prepared: 5/29/2019 11:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	4,658,763	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	293,357	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	1,058,486	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,153,093	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	508,622	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	8,702,002	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	114,018	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	918,856	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,612,517	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	765,551	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	116,818	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,489,844	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	22,429	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,292,184	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	18,753,545	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	919,430	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	67,379,515		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 11:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	393,952	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	12,599	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	180	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	175,859	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	12,740	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	412,377	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	31,307	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	239,193	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	71,655	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	21,437	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,179	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	163,483	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	7,449	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	485,078	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	3,133	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,036,621	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 11:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.327148	0	1,495,280	0	0	50.00
51.00	05100	RECOVERY ROOM	0.365800	0	122,024	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.424938	0	534,704	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152723	0	6,239,562	352	0	54.00
56.00	05600	RADIOISOTOPE	0.264053	0	240,389	0	0	56.00
60.00	06000	LABORATORY	0.146304	0	2,898,801	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.503727	0	40,103	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.971178	0	168,729	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.419000	0	1,071,950	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570502	0	275,735	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.551987	0	22,286	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.152809	0	1,467,572	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4.348790	0	1,484	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299573	0	1,873,841	2,077	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.323178	0	4,454,651	1,537	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.313809	0	527,805	0	0	92.00
200.00		Subtotal (see instructions)		0	21,434,916	3,966	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	21,434,916	3,966	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 11:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	489,178	0	50.00
51.00	05100	RECOVERY ROOM	44,636	0	51.00
51.01	05101	O/P TREATMENT ROOM	227,216	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	952,925	54	54.00
56.00	05600	RADIOISOTOPE	63,475	0	56.00
60.00	06000	LABORATORY	424,106	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	20,201	0	62.00
65.00	06500	RESPIRATORY THERAPY	163,866	0	65.00
66.00	06600	PHYSICAL THERAPY	449,147	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	157,307	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,302	0	68.00
69.00	06900	ELECTROCARDIOLOGY	224,258	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,454	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	561,352	622	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	1,439,645	497	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	693,435	0	92.00
200.00		Subtotal (see instructions)	5,929,503	1,173	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	5,929,503	1,173	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1326 Component CCN: 15-Z326	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 11:50 am
	Title XVIII	Swing Beds - SNF	Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.327148	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.365800	0	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.424938	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152723	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.264053	0	0	0	0	56.00
60.00	06000	LABORATORY	0.146304	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.503727	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.971178	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.419000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570502	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.551987	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.152809	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4.348790	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299573	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.323178	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.313809	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V

Component CCN: 15-Z326 | Date/Time Prepared: 5/29/2019 11:50 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 11:50 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,235	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,068	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,376	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	167	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)	887	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)	161	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.02	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,901,424	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)	291,515	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,609,909	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,609,909	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)	1,745.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,548,347	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,548,347	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 11:50 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,608,951	316	5,091.62	155	789,201	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	721,558	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,059,106	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)	281,042	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)	281,042	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)	692	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,745.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,207,955	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 11:50 am
	Title XVIII	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	615,697	3,901,424	0.157813	1,207,955	190,631	90.00
91.00	Nursing School cost	0	3,901,424	0.000000	1,207,955	0	91.00
92.00	Allied health cost	0	3,901,424	0.000000	1,207,955	0	92.00
93.00	All other Medical Education	0	3,901,424	0.000000	1,207,955	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 11:50 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)	2,235	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,068	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,376	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	167	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)	17	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	3,901,424	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)	291,515	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,609,909	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,609,909	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)	1,745.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	29,675	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)	29,675	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 11:50 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,608,951	316	5,091.62	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	16,311	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	45,986	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)	692	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,745.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,207,955	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 11:50 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	615,697	3,901,424	0.157813	1,207,955	190,631	90.00
91.00	Nursing School cost	0	3,901,424	0.000000	1,207,955	0	91.00
92.00	Allied health cost	0	3,901,424	0.000000	1,207,955	0	92.00
93.00	All other Medical Education	0	3,901,424	0.000000	1,207,955	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 11:50 am

		Cost Center Description	Title XVIII Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,581,215		30.00
31.00	03100	INTENSIVE CARE UNIT		357,206		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.327148	393,952	128,881	50.00
51.00	05100	RECOVERY ROOM	0.365800	12,599	4,609	51.00
51.01	05101	O/P TREATMENT ROOM	0.424938	180	76	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152723	175,859	26,858	54.00
56.00	05600	RADIOISOTOPE	0.264053	12,740	3,364	56.00
60.00	06000	LABORATORY	0.146304	412,377	60,332	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.503727	31,307	15,770	62.00
65.00	06500	RESPIRATORY THERAPY	0.971178	239,193	232,299	65.00
66.00	06600	PHYSICAL THERAPY	0.419000	71,655	30,023	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570502	21,437	12,230	67.00
68.00	06800	SPEECH PATHOLOGY	0.551987	6,179	3,411	68.00
69.00	06900	ELECTROCARDIOLOGY	0.152809	163,483	24,982	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4.348790	7,449	32,394	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299573	485,078	145,316	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.323178	3,133	1,013	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.313809	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,036,621	721,558	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,036,621		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 11:50 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.327148	209	68	50.00
51.00	05100	RECOVERY ROOM	0.365800	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.424938	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152723	1,645	251	54.00
56.00	05600	RADIOISOTOPE	0.264053	4,959	1,309	56.00
60.00	06000	LABORATORY	0.146304	17,046	2,494	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.503727	1,234	622	62.00
65.00	06500	RESPIRATORY THERAPY	0.971178	21,253	20,640	65.00
66.00	06600	PHYSICAL THERAPY	0.419000	26,957	11,295	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570502	10,164	5,799	67.00
68.00	06800	SPEECH PATHOLOGY	0.551987	500	276	68.00
69.00	06900	ELECTROCARDIOLOGY	0.152809	2,139	327	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4.348790	57	248	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299573	35,141	10,527	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.323178	4	1	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.313809	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		121,308	53,857	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)		121,308		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/29/2019 11:50 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		15,628		30.00
31.00	03100	INTENSIVE CARE UNIT		11,090		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.327148	9,574	3,132	50.00
51.00	05100	RECOVERY ROOM	0.365800	217	79	51.00
51.01	05101	O/P TREATMENT ROOM	0.424938	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152723	12,858	1,964	54.00
56.00	05600	RADIOISOTOPE	0.264053	239	63	56.00
60.00	06000	LABORATORY	0.146304	13,365	1,955	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.503727	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.971178	3,109	3,019	65.00
66.00	06600	PHYSICAL THERAPY	0.419000	270	113	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570502	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.551987	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.152809	2,447	374	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4.348790	16	70	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299573	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.323178	17,147	5,542	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.313809	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		59,242	16,311	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)		59,242		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3

Component CCN: 15-Z326 | Date/Time Prepared: 5/29/2019 11:50 am

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.327148	0	0	50.00
51.00	05100	RECOVERY ROOM	0.365800	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.424938	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152723	0	0	54.00
56.00	05600	RADIOISOTOPE	0.264053	0	0	56.00
60.00	06000	LABORATORY	0.146304	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.503727	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.971178	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.419000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.570502	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.551987	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.152809	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4.348790	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299573	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.323178	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.313809	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 11:50 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,930,676	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,930,676	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,989,983	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	70,479	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,681,088	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)	2,238,416	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)	2,238,416	30.00
31.00	Primary payer payments	651	31.00
32.00	Subtotal (line 30 minus line 31)	2,237,765	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,130,304	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	734,698	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	897,024	36.00
37.00	Subtotal (see instructions)	2,972,463	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,972,463	40.00
40.01	Sequestration adjustment (see instructions)	59,449	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,779,715	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	133,299	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: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2019 11:50 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,690,894		2,267,915	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/23/2018	361,700	08/23/2018	511,800	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)		361,700		511,800	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,052,594		2,779,715	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		133,299	6.01
6.02	SETTLEMENT TO PROGRAM		360,208		0	6.02
7.00	Total Medicare program liability (see instructions)		2,692,386		2,913,014	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 11:50 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		348,805		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		348,805		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		20,379		0	6.02
7.00	Total Medicare program liability (see instructions)		328,426		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/29/2019 11:50 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1326 Component CCN: 15-Z326	Period: From 01/01/2018 To 12/31/2018	Worksheet E-2 Date/Time Prepared: 5/29/2019 11:50 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	283,852	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	54,396	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	161	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	338,248	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	338,248	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	338,248	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,188	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	334,060	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	1,645	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	1,069	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,645	0	18.00
19.00	Total (see instructions)	335,129	0	19.00
19.01	Sequestration adjustment (see instructions)	6,703	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	348,805	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-20,379	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 5/29/2019 11:50 am

Title XIX | Swing Beds - SNF | Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/29/2019 11:50 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,059,106	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,059,106	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,089,697	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,089,697	19.00
20.00	Deductibles (exclude professional component)	376,444	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,713,253	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,713,253	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	52,431	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	34,080	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	19,562	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,747,333	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,747,333	30.00
30.01	Sequestration adjustment (see instructions)	54,947	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	3,052,594	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-360,208	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-3 Part VII Date/Time Prepared: 5/29/2019 11:50 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	45,986		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	45,986	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	45,986	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	26,718		8.00
9.00	Ancillary service charges	59,242	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	85,960	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	85,960	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	39,974	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	45,986	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	45,986	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	45,986	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	45,986	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	45,986	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	45,986	0	40.00
41.00	Interim payments	49,077	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-3,091	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: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/29/2019 11:50 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	2,974	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,375,643	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	259,611	0	0	0	7.00
8.00	Prepaid expenses	33,108,471	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	35,746,699	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	609,760	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	13,424,619	0	0	0	15.00
16.00	Accumulated depreciation	-14,060,963	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,960,479	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	6,933,895	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,680,594	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	437,730	0	0	0	37.00
38.00	Salaries, wages, and fees payable	784,640	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	884,656	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,107,026	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	2,269,525	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,269,525	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,376,551	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	38,304,043				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	38,304,043	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,680,594	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/29/2019 11:50 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		35,834,466		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,469,577				2.00
3.00	Total (sum of line 1 and line 2)		38,304,043		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		38,304,043		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		38,304,043		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2019 11:50 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,652,512		2,652,512	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)	2,652,512		2,652,512	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	994,292		994,292	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	994,292		994,292	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,646,804		3,646,804	17.00
18.00	Ancillary services	4,148,614	43,557,926	47,706,540	18.00
19.00	Outpatient services	531,323	19,141,652	19,672,975	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 REVENUE	0	14,922	14,922	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,326,741	62,714,500	71,041,241	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,009,438		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)		20,009,438		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1326	Period: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 5/29/2019 11:50 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	71,041,241	1.00
2.00	Less contractual allowances and discounts on patients' accounts	47,474,979	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,566,262	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,009,438	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,556,824	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	362,863	24.00
24.01	INVESTMENT INCOME	-1,176	24.01
24.02	OTHER	2,623	24.02
24.03	CHANGES IN UHF	1,884	24.03
25.00	Total other income (sum of lines 6-24)	366,194	25.00
26.00	Total (line 5 plus line 25)	3,923,018	26.00
27.00	LOSS ON SALE OF EQUIPMENT	1,453,441	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1,453,441	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,469,577	29.00