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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/26/2019 7:45 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/26/2019 Time: 7:45 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 ST. JOSEPH HOSPITAL & HEALTH CENTER (15-0010) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 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	209,840	-152,355	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	6,871	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	216,711	-152,355	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 7:45 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1907 WEST SYCAMORE STREET	PO Box:			1.00
2.00	City: KOKOMO	State: IN	Zip Code: 46901	County: HOWARD	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. JOSEPH HOSPITAL & HEALTH CENTER	150010	29020	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	ST. JOSEPH ACUTE REHAB	15T010	29020	5	07/01/2002	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2018	06/30/2019	20.00
21.00	Type of Control (see instructions)	1		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	Y	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.	485	229	0	10	3,641	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 7:45 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	18	0	0	284		25.00

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				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)	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 7:45 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 7:45 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.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 7:45 am

			1.00	
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	581,542	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 7:45 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 250 W 96TH STREET, SUITE 215	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46260	143.00

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2018	12/31/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-2 Part II Date/Time Prepared: 11/26/2019 7:45 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.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		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	10/28/2019	Y	10/28/2019	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

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

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ASCENSION HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3519	JILL.HILL1@ASCENSION.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/26/2019 7:45 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.	NET REVENUE MANAGEMENT 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: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 11/26/2019 7:45 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	98	35,770	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		98	35,770	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	13	4,745	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		111	40,515	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	18	6,570		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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)		129				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)		8	2,920			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: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2019 7:45 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)	5,208	325	13,735			1.00
2.00	HMO and other (see instructions)	2,999	3,641				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	571	284				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,208	325	13,735			7.00
8.00	INTENSIVE CARE UNIT	960	210	1,972			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		189	1,850			13.00
14.00	Total (see instructions)	6,168	724	17,557	0.00	470.03	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	2,421	18	3,935	0.00	0.00	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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	470.03	27.00
28.00	Observation Bed Days		0	973			28.00
29.00	Ambulance Trips	1,885					29.00
30.00	Employee discount days (see instruction)			139			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	479			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: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2019 7:45 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,489	135	4,522	1.00
2.00	HMO and other (see instructions)			624	1,212		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,489	135	4,522	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	212	23	325	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part II Date/Time Prepared: 11/26/2019 7:45 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	31,284,853	0	31,284,853	977,357.84	32.01	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		72,000	0	72,000	720.00	100.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		1,068,576	0	1,068,576	17,163.58	62.26	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		2,993,552	244,815	3,238,367	93,302.10	34.71	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		835,058	0	835,058	7,642.48	109.27	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		132,591	0	132,591	1,680.00	78.92	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		8,187,345	0	8,187,345	172,714.00	47.40	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,084,762	0	8,084,762			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		552,369	0	552,369			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		15,898	0	15,898			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		235,944	0	235,944			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		2,524,994	0	2,524,994			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	66,864	0	66,864	1,612.00	41.48	26.00
27.00	Administrative & General	5.00	2,544,225	0	2,544,225	73,961.00	34.40	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part II Date/Time Prepared: 11/26/2019 7:45 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		839,115	0	839,115	4,992.00	168.09	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	293,175	0	293,175	15,373.00	19.07	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,331,499	0	1,331,499	61,944.00	21.50	33.00
34.00	Dietary	10.00	38	0	38	3.00	12.67	34.00
35.00	Dietary under contract (see instructions)		454,501	0	454,501	20,763.00	21.89	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,204,109	0	1,204,109	31,016.00	38.82	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,416,873	0	1,416,873	30,539.00	46.40	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet S-3 Part III Date/Time Prepared: 11/26/2019 7:45 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		32,841,392	0	32,841,392	1,047,893.26	31.34	1.00
2.00	Excluded area salaries (see instructions)		2,993,552	244,815	3,238,367	93,302.10	34.71	2.00
3.00	Subtotal salaries (line 1 minus line 2)		29,847,840	-244,815	29,603,025	954,591.16	31.01	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,154,994	0	9,154,994	182,036.48	50.29	4.00
5.00	Subtotal wage-related costs (see inst.)		10,625,654	0	10,625,654	0.00	35.89	5.00
6.00	Total (sum of lines 3 thru 5)		49,628,488	-244,815	49,383,673	1,136,627.64	43.45	6.00
7.00	Total overhead cost (see instructions)		8,150,399	0	8,150,399	240,203.00	33.93	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 11/26/2019 7:45 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,368,861	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	476,610	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	293,952	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,270,199	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	825,859	9.00
10.00	Dental, Hearing and Vision Plan	105,866	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	8,749	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-383	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	226,052	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	74,913	14.00
15.00	'Workers' Compensation Insurance	7,971	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,181,943	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	18,443	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	29,937	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,888,972	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet S-3 Part V | Date/Time Prepared: 11/26/2019 7:45 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	835,058	8,888,972	1.00
2.00	Hospital	835,058	8,888,972	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet S-10 Date/Time Prepared: 11/26/2019 7:45 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)	0.221724	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	12,081,942	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	83,980,244	6.00
7.00	Medicaid cost (line 1 times line 6)	18,620,436	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)	6,538,494	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)	6,538,494	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)	12,617,007	3,463,318	16,080,325	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,797,493	3,463,318	6,260,811	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)	2,797,493	3,463,318	6,260,811	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,967,460	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	130,579	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	200,890	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,766,570	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	683,726	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,944,537	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	13,483,031	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A | Date/Time Prepared: 11/26/2019 7:45 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,881,869	2,881,869	0	2,881,869	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,636,052	2,636,052	0	2,636,052	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	66,864	6,641,714	6,708,578	0	6,708,578	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,544,225	40,877,141	43,421,366	0	43,421,366	5.00
7.00	00700	OPERATION OF PLANT	293,175	3,880,784	4,173,959	0	4,173,959	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	406,094	406,094	8.00
9.00	00900	HOUSEKEEPING	0	1,921,193	1,921,193	-348,010	1,573,183	9.00
10.00	01000	DIETARY	38	2,204,500	2,204,538	-1,525,713	678,825	10.00
11.00	01100	CAFETERIA	0	0	0	1,525,713	1,525,713	11.00
13.00	01300	NURSING ADMINISTRATION	1,204,109	283,152	1,487,261	0	1,487,261	13.00
15.00	01500	PHARMACY	1,416,873	266,287	1,683,160	0	1,683,160	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	36	36	0	36	16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	75,780	36,543	112,323	244,815	357,138	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,698,571	874,534	5,573,105	390,275	5,963,380	30.00
31.00	03100	INTENSIVE CARE UNIT	1,262,615	118,362	1,380,977	0	1,380,977	31.00
41.00	04100	SUBPROVIDER - IRF	988,699	102,398	1,091,097	0	1,091,097	41.00
43.00	04300	NURSERY	0	0	0	472,655	472,655	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,043,146	1,926,685	4,969,831	0	4,969,831	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,061,142	233,907	2,295,049	-862,930	1,432,119	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,566,674	1,259,567	2,826,241	-245,985	2,580,256	54.00
54.01	03630	ULTRA SOUND	289,867	23,061	312,928	0	312,928	54.01
56.00	05600	RADIOISOTOPE	635,556	327,007	962,563	0	962,563	56.00
57.00	05700	CT SCAN	360,851	28,297	389,148	0	389,148	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	270,426	25,264	295,690	0	295,690	58.00
59.00	05900	CARDIAC CATHETERIZATION	32,613	33,210	65,823	0	65,823	59.00
60.00	06000	LABORATORY	0	5,568,772	5,568,772	0	5,568,772	60.00
65.00	06500	RESPIRATORY THERAPY	847,029	79,680	926,709	0	926,709	65.00
66.00	06600	PHYSICAL THERAPY	3,166,054	453,602	3,619,656	-1,105,256	2,514,400	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	886,256	886,256	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	171,252	171,252	68.00
69.00	06900	ELECTROCARDIOLOGY	625,172	74,535	699,707	0	699,707	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	383,168	135,150	518,318	-9,166	509,152	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	227,057	3,284,620	3,511,677	0	3,511,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,487,625	2,487,625	0	2,487,625	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,925,259	3,925,259	11,915,710	15,840,969	73.00
74.00	07400	RENAL DIALYSIS	0	241,621	241,621	0	241,621	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	888,642	85,943	974,585	0	974,585	76.00
76.01	03190	CHEMOTHERAPY	416,062	16,739,930	17,155,992	-11,915,710	5,240,282	76.01
76.02	03330	ENDOSCOPY	40,541	17,594	58,135	0	58,135	76.02
76.03	03950	WOUND CARE CENTER	202,203	605,145	807,348	0	807,348	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,748,628	461,463	2,210,091	0	2,210,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	870,794	104,230	975,024	0	975,024	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,226,574	100,846,732	131,073,306	0	131,073,306	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	921,823	2,332,333	3,254,156	0	3,254,156	192.00
192.01	19201	ASC MOB	0	148	148	0	148	192.01
192.02	19202	EDUCATION CENTER	0	13,732	13,732	0	13,732	192.02
192.03	19203	MARKETING	0	291	291	0	291	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	136,456	28,320	164,776	0	164,776	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	31,284,853	103,221,556	134,506,409	0	134,506,409	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A | Date/Time Prepared: 11/26/2019 7:45 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,203	2,886,072	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,674	2,634,378	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,587	6,706,991	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,547,805	35,873,561	5.00
7.00	00700	OPERATION OF PLANT	-48,569	4,125,390	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	406,094	8.00
9.00	00900	HOUSEKEEPING	0	1,573,183	9.00
10.00	01000	DIETARY	-484,864	193,961	10.00
11.00	01100	CAFETERIA	0	1,525,713	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,487,261	13.00
15.00	01500	PHARMACY	41	1,683,201	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-52,422	-52,386	16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	-24,765	332,373	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-489,031	5,474,349	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,380,977	31.00
41.00	04100	SUBPROVIDER - IRF	0	1,091,097	41.00
43.00	04300	NURSERY	0	472,655	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-184,808	4,785,023	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,432,119	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-146,735	2,433,521	54.00
54.01	03630	ULTRA SOUND	0	312,928	54.01
56.00	05600	RADIOISOTOPE	-29,581	932,982	56.00
57.00	05700	CT SCAN	0	389,148	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	295,690	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	65,823	59.00
60.00	06000	LABORATORY	-3,942	5,564,830	60.00
65.00	06500	RESPIRATORY THERAPY	0	926,709	65.00
66.00	06600	PHYSICAL THERAPY	-24,252	2,490,148	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	886,256	67.00
68.00	06800	SPEECH PATHOLOGY	0	171,252	68.00
69.00	06900	ELECTROCARDIOLOGY	0	699,707	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	509,152	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,511,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,487,625	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,840,969	73.00
74.00	07400	RENAL DIALYSIS	0	241,621	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-166,764	807,821	76.00
76.01	03190	CHEMOTHERAPY	-56,400	5,183,882	76.01
76.02	03330	ENDOSCOPY	0	58,135	76.02
76.03	03950	WOUND CARE CENTER	-2,969	804,379	76.03
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	2,210,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	975,024	95.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,261,924	121,811,382	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,254,156	192.00
192.01	19201	ASC MOB	0	148	192.01
192.02	19202	EDUCATION CENTER	0	13,732	192.02
192.03	19203	MARKETING	0	291	192.03
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	FOUNDATION	0	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	194.01
194.02	07952	CLINIC OF HOPE	0	164,776	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,261,924	125,244,485	200.00

RECLASSIFICATIONS	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet A-6 Date/Time Prepared: 11/26/2019 7:45 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LAUNDRY AND LINEN RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	406,094	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	0		0	406,094	
	B - LABOR DELIVERY_OB_NURSERY RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	350,499	39,776	1.00
2.00	NURSERY	43.00	424,483	48,172	2.00
	0		774,982	87,948	
	C - DIETARY_CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	0	1,525,713	1.00
	0		0	1,525,713	
	E - CHEMOTHERAPY DRUG RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,915,710	1.00
	0		0	11,915,710	
	F - PT_OT_ST RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	775,194	111,062	1.00
2.00	SPEECH PATHOLOGY	68.00	149,791	21,461	2.00
	0		924,985	132,523	
	G - AH-RAD TECH PRECEPTING EXPENSE				
1.00	ALLIED HEALTH-RAD TECH PROGRAM	23.00	244,815	0	1.00
	0		244,815	0	
500.00	Grand Total: Increases		1,944,782	14,067,988	500.00

RECLASSIFICATIONS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-6 | Date/Time Prepared: 11/26/2019 7:45 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LAUNDRY AND LINEN RECLASS						
1.00	HOUSEKEEPING	9.00	0	348,010	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,170	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	22,068	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	13,492	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	12,188	0		5.00
6.00	ELECTROENCEPHALOGRAPHY	70.00	0	9,166	0		6.00
	0		0	406,094			
	B - LABOR DELIVERY_OB_NURSERY RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	774,982	87,948	0		1.00
2.00		0.00	0	0	0		2.00
	0		774,982	87,948			
	C - DIETARY_CAFETERIA RECLASS						
1.00	DIETARY	10.00	0	1,525,713	0		1.00
	0		0	1,525,713			
	E - CHEMOTHERAPY DRUG RECLASS						
1.00	CHEMOTHERAPY	76.01	0	11,915,710	0		1.00
	0		0	11,915,710			
	F - PT_OT_ST RECLASS						
1.00	PHYSICAL THERAPY	66.00	924,985	132,523	0		1.00
2.00		0.00	0	0	0		2.00
	0		924,985	132,523			
	G - AH-RAD TECH PRECEPTING EXPENSE						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	244,815	0	0		1.00
	0		244,815	0			
500.00	Grand Total: Decreases		1,944,782	14,067,988			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-7 Part I Date/Time Prepared: 11/26/2019 7:45 am

		Beginning Balances	Acquisitions Purchases	Acquisitions Donation	Acquisitions Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	722,779	0	0	0	0	1.00
2.00	Land Improvements	1,764,978	0	0	0	0	2.00
3.00	Buildings and Fixtures	56,139,889	0	0	0	0	3.00
4.00	Building Improvements	10,503,787	4,247,720	0	4,247,720	0	4.00
5.00	Fixed Equipment	21,765,516	0	0	0	0	5.00
6.00	Movable Equipment	41,257,813	5,056,053	0	5,056,053	124,698	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	132,154,762	9,303,773	0	9,303,773	124,698	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	132,154,762	9,303,773	0	9,303,773	124,698	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	722,779	0	1.00
2.00	Land Improvements	1,764,978	0	2.00
3.00	Buildings and Fixtures	56,139,889	0	3.00
4.00	Building Improvements	14,751,507	0	4.00
5.00	Fixed Equipment	21,765,516	0	5.00
6.00	Movable Equipment	46,189,168	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	141,333,837	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	141,333,837	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-7 Part II Date/Time Prepared: 11/26/2019 7:45 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,469,967	411,902	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,347,214	288,838	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,817,181	700,740	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2,881,869	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,636,052	2.00
3.00	Total (sum of lines 1-2)	0	5,517,921	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-7 Part III Date/Time Prepared: 11/26/2019 7:45 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	CAP REL COSTS-BLDG & FIXT	104,252,922	0	104,252,922	0.692854	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	46,215,847	0	46,215,847	0.307146	0	2.00
3.00	Total (sum of lines 1-2)	150,468,769	0	150,468,769	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	CAP REL COSTS-BLDG & FIXT	0	0	0	2,469,967	411,902	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,345,540	288,838	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,815,507	700,740	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	CAP REL COSTS-BLDG & FIXT	4,203	0	0	0	2,886,072	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,634,378	2.00
3.00	Total (sum of lines 1-2)	4,203	0	0	0	5,520,450	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8 | Date/Time Prepared: 11/26/2019 7:45 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-587,498	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-38,179	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	B	-29,616	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-8,853	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,416,407			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	4,343,053			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-452,990	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	CONTRACT REVENUE	B	-19,167	RADIOISOTOPE	56.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8 | Date/Time Prepared: 11/26/2019 7:45 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS INCOME	B	-237	RADIOISOTOPE	56.00	0	33.01
33.02	BUILDING RENTAL INCOME	B	-21,900	CHEMOTHERAPY	76.01	0	33.02
33.03	CONTRACT REVENUE	B	-34,500	CHEMOTHERAPY	76.01	0	33.03
33.04	BUILDING RENTAL INCOME	B	-2,969	WOUND CARE CENTER	76.03	0	33.04
33.05	MISCELLANEOUS INCOME	B	-24,252	PHYSICAL THERAPY	66.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-3,309	RADIOLOGY-DIAGNOSTIC	54.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	41	PHARMACY	15.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-93	RADIOLOGY-DIAGNOSTIC	54.00	0	33.08
33.09	BUILDING RENTAL INCOME	B	-332	RADIOLOGY-DIAGNOSTIC	54.00	0	33.09
33.10	MISCELLANEOUS INCOME	B	-4,143	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11	GAIN ON DISPOSAL OF EQUIPMENT	B	-8,000	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.11
33.12	LAB SERVICES REVENUE	B	-3,922	LABORATORY	60.00	0	33.12
33.13	MISCELLANEOUS INCOME	B	-20	LABORATORY	60.00	0	33.13
33.14	MISCELLANEOUS INCOME	B	5	DIETARY	10.00	0	33.14
33.15	MISCELLANEOUS INCOME	B	-52	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	MISCELLANEOUS INCOME	B	-87,262	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	MISCELLANEOUS INCOME	B	-52,422	MEDICAL RECORDS & LIBRARY	16.00	0	33.17
33.18	MISCELLANEOUS INCOME	B	-750	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	MISCELLANEOUS INCOME	B	-1,734	OPERATION OF PLANT	7.00	0	33.19
33.20	MEALS ON WHEELS INCOME	B	-31,308	DIETARY	10.00	0	33.20
33.21	MISCELLANEOUS INCOME	B	-571	DIETARY	10.00	0	33.21
33.22	IC RENTAL INCOME	B	-43,086	OPERATION OF PLANT	7.00	0	33.22
33.23	TUITION REVENUE	B	-5,820	ALLIED HEALTH-RAD TECH PROGRAM	23.00	0	33.23
33.24	MISCELLANEOUS INCOME	B	-18,945	ALLIED HEALTH-RAD TECH PROGRAM	23.00	0	33.24
33.25	LOBBYING OFFSET	A	-1,139	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	PROVIDER TAX ASSESSMENT	A	-10,537,902	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	TELEVISION UTILITY EXPENSE	A	-3,749	OPERATION OF PLANT	7.00	0	33.27
33.28	CHARITABLE DONATIONS	A	-3,405	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	MARKETING EXPENSE	A	-16,504	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	CORPORATE SPONSORSHIPS	A	-34,805	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	AHA LIFE ADJUSTMENT	A	6,326	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.31
33.32	LATE FEE/PENALTIES	A	-666	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	MID LEVEL PROVIDER OFFSET	A	-14,738	ADULTS & PEDIATRICS	30.00	0	33.33
33.34	MID LEVEL PROVIDER OFFSET	A	-100,104	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	33.34
33.35	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.35
33.36	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.36
33.37	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.37
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,261,924				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: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8-1 | Date/Time Prepared: 11/26/2019 7:45 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH HEALTH INSURANCE	6,296,803	6,296,803	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	SVH HOME OFFICE ALLOCATION	27,011,655	25,705,504	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACK	37,585	37,585	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK	113,978	113,978	3.01
3.02	15.00	PHARMACY	SVH CHARGEBACK	-88,649	-88,649	3.02
3.03	23.00	ALLIED HEALTH-RAD TECH PROGR	SVH CHARGEBACK	28,285	28,285	3.03
3.04	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	67,835	67,835	3.04
3.05	56.00	RADIOISOTOPE	SVH CHARGEBACK	3,192	3,192	3.05
3.06	59.00	CARDIAC CATHETERIZATION	SVH CHARGEBACK	5,000	5,000	3.06
3.07	69.00	ELECTROCARDIOLOGY	SVH CHARGEBACK	5,000	5,000	3.07
3.08	192.00	PHYSICIANS' PRIVATE OFFICES	SVH CHARGEBACK	2,267,299	2,267,299	3.08
4.00	5.00	ADMINISTRATIVE & GENERAL	SVH CAPITAL	2,411,225	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SVH INTEREST	33,976	0	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE INTEREST EXPENSE	591,701	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			38,784,885	34,441,832	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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office 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	Related Organization Name	Percentage of Ownership	
6.00	B		0.00	ASCENSION	100.00	6.00
7.00	B		0.00	SV HEALTH	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet A-8-1 Date/Time Prepared: 11/26/2019 7:45 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	0	0	1.00
2.00	1,306,151	0	2.00
3.00	0	0	3.00
3.01	0	0	3.01
3.02	0	0	3.02
3.03	0	0	3.03
3.04	0	0	3.04
3.05	0	0	3.05
3.06	0	0	3.06
3.07	0	0	3.07
3.08	0	0	3.08
4.00	2,411,225	0	4.00
4.01	33,976	0	4.01
4.02	591,701	11	4.02
5.00	4,343,053		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	HEALTH MGMT	6.00
7.00	HEALTH MGMT	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: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet A-8-2 | Date/Time Prepared: 11/26/2019 7:45 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	4.00	DR. A	837	837	0	0	0	1.00
2.00	5.00	DR. B	531,774	459,774	72,000	211,500	720	2.00
3.00	30.00	DR. C	67,165	67,165	0	0	0	3.00
4.00	50.00	DR. D	184,808	184,808	0	0	0	4.00
5.00	76.00	DR. E	45,850	45,850	0	0	0	5.00
6.00	5.00	DR. F	81,000	0	0	0	0	6.00
7.00	30.00	DR. G	407,128	0	0	0	0	7.00
8.00	54.00	DR. H	138,858	0	0	0	0	8.00
9.00	56.00	DR. I	18,922	0	18,922	211,500	86	9.00
10.00	60.00	DR. J	132,591	0	132,591	211,500	1,680	10.00
11.00	76.00	DR. K	20,810	20,810	0	0	0	11.00
200.00			1,629,743	779,244	223,513		2,486	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	4.00	DR. A	0	0	0	0	0	1.00
2.00	5.00	DR. B	73,212	3,661	0	0	0	2.00
3.00	30.00	DR. C	0	0	0	0	0	3.00
4.00	50.00	DR. D	0	0	0	0	0	4.00
5.00	76.00	DR. E	0	0	0	0	0	5.00
6.00	5.00	DR. F	0	0	0	0	0	6.00
7.00	30.00	DR. G	0	0	0	0	0	7.00
8.00	54.00	DR. H	0	0	0	0	0	8.00
9.00	56.00	DR. I	8,745	437	0	0	0	9.00
10.00	60.00	DR. J	170,827	8,541	0	0	0	10.00
11.00	76.00	DR. K	0	0	0	0	0	11.00
200.00			252,784	12,639	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	4.00	DR. A	0	0	0	837	1.00
2.00	5.00	DR. B	0	73,212	0	459,774	2.00
3.00	30.00	DR. C	0	0	0	67,165	3.00
4.00	50.00	DR. D	0	0	0	184,808	4.00
5.00	76.00	DR. E	0	0	0	45,850	5.00
6.00	5.00	DR. F	0	0	0	81,000	6.00
7.00	30.00	DR. G	0	0	0	407,128	7.00
8.00	54.00	DR. H	0	0	0	138,858	8.00
9.00	56.00	DR. I	0	8,745	10,177	10,177	9.00
10.00	60.00	DR. J	0	170,827	0	0	10.00
11.00	76.00	DR. K	0	0	0	20,810	11.00
200.00			0	252,784	10,177	1,416,407	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I Date/Time Prepared: 11/26/2019 7:45 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,886,072	2,886,072				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,634,378		2,634,378			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,706,991	111,635	245	6,818,871		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,873,561	436,375	25,483	555,730	36,891,149	5.00
7.00	00700	OPERATION OF PLANT	4,125,390	400,476	131,270	64,038	4,721,174	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	406,094	4,511	5,847	0	416,452	8.00
9.00	00900	HOUSEKEEPING	1,573,183	17,546	0	0	1,590,729	9.00
10.00	01000	DIETARY	193,961	45,325	9,494	8	248,788	10.00
11.00	01100	CAFETERIA	1,525,713	54,947	21,341	0	1,602,001	11.00
13.00	01300	NURSING ADMINISTRATION	1,487,261	47,554	168,185	263,011	1,966,011	13.00
15.00	01500	PHARMACY	1,683,201	27,857	0	309,485	2,020,543	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-52,386	21,308	8,027	0	-23,051	16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	332,373	7,802	0	70,027	410,202	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,474,349	256,395	69,543	1,102,845	6,903,132	30.00
31.00	03100	INTENSIVE CARE UNIT	1,380,977	49,078	52,035	275,790	1,757,880	31.00
41.00	04100	SUBPROVIDER - IRF	1,091,097	118,149	567	215,960	1,425,773	41.00
43.00	04300	NURSERY	472,655	14,011	15,088	92,719	594,473	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,785,023	284,304	343,437	664,708	6,077,472	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,432,119	28,423	45,715	280,933	1,787,190	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,433,521	207,431	772,844	288,731	3,702,527	54.00
54.01	03630	ULTRA SOUND	312,928	0	7,979	63,315	384,222	54.01
56.00	05600	RADIOISOTOPE	932,982	17,416	220,260	138,823	1,309,481	56.00
57.00	05700	CT SCAN	389,148	0	1,904	78,820	469,872	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	295,690	0	0	59,069	354,759	58.00
59.00	05900	CARDIAC CATHETERIZATION	65,823	3,483	16,245	7,124	92,675	59.00
60.00	06000	LABORATORY	5,564,830	68,792	3,107	0	5,636,729	60.00
65.00	06500	RESPIRATORY THERAPY	926,709	10,772	45,468	185,015	1,167,964	65.00
66.00	06600	PHYSICAL THERAPY	2,490,148	62,827	38,189	489,512	3,080,676	66.00
67.00	06700	OCCUPATIONAL THERAPY	886,256	26,960	5,020	169,324	1,087,560	67.00
68.00	06800	SPEECH PATHOLOGY	171,252	9,056	2,060	32,719	215,087	68.00
69.00	06900	ELECTROCARDIOLOGY	699,707	34,858	154,621	136,555	1,025,741	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	509,152	23,755	28,793	83,695	645,395	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,511,677	37,522	81,112	49,596	3,679,907	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,487,625	0	0	0	2,487,625	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,840,969	0	0	0	15,840,969	73.00
74.00	07400	RENAL DIALYSIS	241,621	0	0	0	241,621	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	807,821	39,978	0	194,104	1,041,903	76.00
76.01	03190	CHEMOTHERAPY	5,183,882	0	67,114	90,880	5,341,876	76.01
76.02	03330	ENDOSCOPY	58,135	0	7,663	8,855	74,653	76.02
76.03	03950	WOUND CARE CENTER	804,379	26,124	0	44,167	874,670	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,210,091	168,411	82,440	381,949	2,842,891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	975,024	34,553	180,700	190,206	1,380,483	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	121,811,382	2,697,634	2,611,796	6,587,713	121,369,204	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,960	0	0	8,960	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,254,156	177,911	12,529	201,352	3,645,948	192.00
192.01	19201	ASC MOB	148	0	9,800	0	9,948	192.01
192.02	19202	EDUCATION CENTER	13,732	0	0	0	13,732	192.02
192.03	19203	MARKETING	291	0	0	0	291	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	1,567	97	0	1,664	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	164,776	0	156	29,806	194,738	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)	125,244,485	2,886,072	2,634,378	6,818,871	125,244,485	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I Date/Time Prepared: 11/26/2019 7:45 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,891,149					5.00
7.00	00700	OPERATION OF PLANT	1,970,769	6,691,943				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	173,840	15,579	605,871			8.00
9.00	00900	HOUSEKEEPING	664,021	60,601	186,036	2,501,387		9.00
10.00	01000	DIETARY	103,852	156,540	0	0	509,180	10.00
11.00	01100	CAFETERIA	668,726	189,773	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	820,676	164,239	0	1,915	0	13.00
15.00	01500	PHARMACY	843,439	96,210	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	73,593	0	638	0	16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	171,231	26,947	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,881,588	885,526	193,490	783,231	325,405	30.00
31.00	03100	INTENSIVE CARE UNIT	733,795	169,502	51,587	191,530	46,720	31.00
41.00	04100	SUBPROVIDER - IRF	595,163	408,057	5,068	191,530	93,226	41.00
43.00	04300	NURSERY	248,152	48,391	7,913	105,367	43,829	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,536,931	981,916	6,062	383,061	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	746,030	98,165	21,451	203,112	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,545,553	716,415	14,065	38,945	0	54.00
54.01	03630	ULTRA SOUND	160,387	0	4,036	8,300	0	54.01
56.00	05600	RADIOISOTOPE	546,619	60,150	0	28,730	0	56.00
57.00	05700	CT SCAN	196,140	0	6,646	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	148,088	0	1,767	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	38,686	12,030	0	12,769	0	59.00
60.00	06000	LABORATORY	2,352,951	237,592	447	79,166	0	60.00
65.00	06500	RESPIRATORY THERAPY	487,546	37,203	410	3,831	0	65.00
66.00	06600	PHYSICAL THERAPY	1,285,973	216,991	0	10,777	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	453,982	93,112	0	2,694	0	67.00
68.00	06800	SPEECH PATHOLOGY	89,784	31,278	380	8,887	0	68.00
69.00	06900	ELECTROCARDIOLOGY	428,177	120,390	0	5,107	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	269,409	82,044	0	32,560	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,536,111	129,593	9,556	71,505	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,038,414	0	42	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,612,546	0	67	28,730	0	73.00
74.00	07400	RENAL DIALYSIS	100,860	0	0	12,769	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	434,924	138,074	3,414	25,537	0	76.00
76.01	03190	CHEMOTHERAPY	2,229,870	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	31,163	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	365,115	90,225	0	40,860	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,186,714	581,649	92,654	229,836	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	576,258	119,337	780	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,273,483	6,041,122	605,871	2,501,387	509,180	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,740	30,947	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,521,935	614,461	0	0	0	192.00
192.01	19201	ASC MOB	4,153	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	5,732	0	0	0	0	192.02
192.03	19203	MARKETING	121	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	695	5,413	0	0	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	81,290	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)	36,891,149	6,691,943	605,871	2,501,387	509,180	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I | Date/Time Prepared: 11/26/2019 7:45 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	ALLIED HEALTH-RAD TECH PROGRAM	
			11.00	13.00	15.00	16.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,460,500					11.00
13.00	01300	NURSING ADMINISTRATION	86,094	3,038,935				13.00
15.00	01500	PHARMACY	84,770	0	3,044,962			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	51,180		16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	7,267	0	0	0	615,647	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	503,555	1,142,726	0	2,742	0	30.00
31.00	03100	INTENSIVE CARE UNIT	102,522	232,654	0	799	0	31.00
41.00	04100	SUBPROVIDER - IRF	92,282	209,416	0	665	0	41.00
43.00	04300	NURSERY	35,711	81,039	0	333	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	269,781	612,217	0	9,042	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	108,204	245,548	0	1,220	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	142,899	0	0	2,399	236,455	54.00
54.01	03630	ULTRA SOUND	17,829	0	0	688	67,844	54.01
56.00	05600	RADIOISOTOPE	48,269	0	0	1,723	169,902	56.00
57.00	05700	CT SCAN	25,657	0	0	1,133	111,749	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,509	0	0	301	29,697	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,434	5,524	0	151	0	59.00
60.00	06000	LABORATORY	0	0	0	6,855	0	60.00
65.00	06500	RESPIRATORY THERAPY	70,403	0	0	1,120	0	65.00
66.00	06600	PHYSICAL THERAPY	217,143	0	0	1,387	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,546	0	0	479	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,717	0	0	93	0	68.00
69.00	06900	ELECTROCARDIOLOGY	54,073	0	0	1,425	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	37,876	0	0	644	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,006	0	0	1,526	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,106	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,024,006	5,864	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	64	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	89,423	0	0	483	0	76.00
76.01	03190	CHEMOTHERAPY	35,983	81,656	0	465	0	76.01
76.02	03330	ENDOSCOPY	2,273	5,159	0	114	0	76.02
76.03	03950	WOUND CARE CENTER	21,640	49,108	0	1,211	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	154,804	351,299	0	6,277	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	114,333	0	0	871	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,414,003	3,016,346	3,024,006	51,180	615,647	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	36,052	0	19,038	0	0	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	491	0	0	0	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	9,954	22,589	1,918	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)	2,460,500	3,038,935	3,044,962	51,180	615,647	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part I | Date/Time Prepared: 11/26/2019 7:45 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	13,621,395	0	13,621,395	30.00
31.00	03100	INTENSIVE CARE UNIT	3,286,989	0	3,286,989	31.00
41.00	04100	SUBPROVIDER - IRF	3,021,180	0	3,021,180	41.00
43.00	04300	NURSERY	1,165,208	0	1,165,208	43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	10,876,482	0	10,876,482	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,210,920	0	3,210,920	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,399,258	0	6,399,258	54.00
54.01	03630	ULTRA SOUND	643,306	0	643,306	54.01
56.00	05600	RADIOISOTOPE	2,164,874	0	2,164,874	56.00
57.00	05700	CT SCAN	811,197	0	811,197	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	553,121	0	553,121	58.00
59.00	05900	CARDIAC CATHETERIZATION	164,269	0	164,269	59.00
60.00	06000	LABORATORY	8,313,740	0	8,313,740	60.00
65.00	06500	RESPIRATORY THERAPY	1,768,477	0	1,768,477	65.00
66.00	06600	PHYSICAL THERAPY	4,812,947	0	4,812,947	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,666,373	0	1,666,373	67.00
68.00	06800	SPEECH PATHOLOGY	357,226	0	357,226	68.00
69.00	06900	ELECTROCARDIOLOGY	1,634,913	0	1,634,913	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,067,928	0	1,067,928	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,458,204	0	5,458,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,527,187	0	3,527,187	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,512,182	0	25,512,182	73.00
74.00	07400	RENAL DIALYSIS	355,314	0	355,314	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,733,758	0	1,733,758	76.00
76.01	03190	CHEMOTHERAPY	7,689,850	0	7,689,850	76.01
76.02	03330	ENDOSCOPY	113,362	0	113,362	76.02
76.03	03950	WOUND CARE CENTER	1,442,829	0	1,442,829	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	5,446,124	0	5,446,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	2,192,062	0	2,192,062	95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	119,010,675	0	119,010,675	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43,647	0	43,647	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,837,434	0	5,837,434	192.00
192.01	19201	ASC MOB	14,101	0	14,101	192.01
192.02	19202	EDUCATION CENTER	19,464	0	19,464	192.02
192.03	19203	MARKETING	412	0	412	192.03
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	FOUNDATION	8,263	0	8,263	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	310,489	0	310,489	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	125,244,485	0	125,244,485	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II | Date/Time Prepared: 11/26/2019 7:45 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	111,635	245	111,880	111,880	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,411,225	436,375	25,483	2,873,083	9,119	5.00
7.00	00700	OPERATION OF PLANT	0	400,476	131,270	531,746	1,051	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,511	5,847	10,358	0	8.00
9.00	00900	HOUSEKEEPING	0	17,546	0	17,546	0	9.00
10.00	01000	DIETARY	0	45,325	9,494	54,819	0	10.00
11.00	01100	CAFETERIA	0	54,947	21,341	76,288	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	47,554	168,185	215,739	4,316	13.00
15.00	01500	PHARMACY	0	27,857	0	27,857	5,078	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,308	8,027	29,335	0	16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	0	7,802	0	7,802	1,149	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	256,395	69,543	325,938	18,089	30.00
31.00	03100	INTENSIVE CARE UNIT	0	49,078	52,035	101,113	4,525	31.00
41.00	04100	SUBPROVIDER - IRF	0	118,149	567	118,716	3,543	41.00
43.00	04300	NURSERY	0	14,011	15,088	29,099	1,521	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	284,304	343,437	627,741	10,907	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	28,423	45,715	74,138	4,610	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	207,431	772,844	980,275	4,738	54.00
54.01	03630	ULTRA SOUND	0	0	7,979	7,979	1,039	54.01
56.00	05600	RADIOISOTOPE	0	17,416	220,260	237,676	2,278	56.00
57.00	05700	CT SCAN	0	0	1,904	1,904	1,293	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	969	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,483	16,245	19,728	117	59.00
60.00	06000	LABORATORY	0	68,792	3,107	71,899	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,772	45,468	56,240	3,036	65.00
66.00	06600	PHYSICAL THERAPY	0	62,827	38,189	101,016	8,032	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	26,960	5,020	31,980	2,778	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,056	2,060	11,116	537	68.00
69.00	06900	ELECTROCARDIOLOGY	0	34,858	154,621	189,479	2,241	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	23,755	28,793	52,548	1,373	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	37,522	81,112	118,634	814	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	39,978	0	39,978	3,185	76.00
76.01	03190	CHEMOTHERAPY	0	0	67,114	67,114	1,491	76.01
76.02	03330	ENDOSCOPY	0	0	7,663	7,663	145	76.02
76.03	03950	WOUND CARE CENTER	0	26,124	0	26,124	725	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	168,411	82,440	250,851	6,267	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	34,553	180,700	215,253	3,121	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,411,225	2,697,634	2,611,796	7,720,655	108,087	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,960	0	8,960	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	177,911	12,529	190,440	3,304	192.00
192.01	19201	ASC MOB	0	0	9,800	9,800	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	1,567	97	1,664	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	0	0	156	156	489	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)	2,411,225	2,886,072	2,634,378	7,931,675	111,880	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II Date/Time Prepared: 11/26/2019 7:45 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,882,202					5.00
7.00	00700	OPERATION OF PLANT	153,972	686,769				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,582	1,599	25,539			8.00
9.00	00900	HOUSEKEEPING	51,878	6,219	7,842	83,485		9.00
10.00	01000	DIETARY	8,114	16,065	0	0	78,998	10.00
11.00	01100	CAFETERIA	52,246	19,476	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	64,118	16,855	0	64	0	13.00
15.00	01500	PHARMACY	65,896	9,874	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,553	0	21	0	16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	13,378	2,765	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	225,132	90,878	8,154	26,140	50,486	30.00
31.00	03100	INTENSIVE CARE UNIT	57,330	17,395	2,175	6,392	7,248	31.00
41.00	04100	SUBPROVIDER - IRF	46,499	41,877	214	6,392	14,464	41.00
43.00	04300	NURSERY	19,388	4,966	334	3,517	6,800	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	198,205	100,771	256	12,785	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	58,286	10,074	904	6,779	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	120,751	73,523	593	1,300	0	54.00
54.01	03630	ULTRA SOUND	12,531	0	170	277	0	54.01
56.00	05600	RADIOISOTOPE	42,706	6,173	0	959	0	56.00
57.00	05700	CT SCAN	15,324	0	280	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,570	0	74	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,022	1,235	0	426	0	59.00
60.00	06000	LABORATORY	183,831	24,383	19	2,642	0	60.00
65.00	06500	RESPIRATORY THERAPY	38,091	3,818	17	128	0	65.00
66.00	06600	PHYSICAL THERAPY	100,470	22,269	0	360	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	35,469	9,556	0	90	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,015	3,210	16	297	0	68.00
69.00	06900	ELECTROCARDIOLOGY	33,452	12,355	0	170	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,048	8,420	0	1,087	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	120,013	13,300	403	2,387	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81,129	0	2	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	516,600	0	3	959	0	73.00
74.00	07400	RENAL DIALYSIS	7,880	0	0	426	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	33,980	14,170	144	852	0	76.00
76.01	03190	CHEMOTHERAPY	174,215	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	2,435	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	28,526	9,259	0	1,364	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	92,715	59,692	3,906	7,671	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	45,022	12,247	33	0	0	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,755,819	619,977	25,539	83,485	78,998	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	292	3,176	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	118,905	63,060	0	0	0	192.00
192.01	19201	ASC MOB	324	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	448	0	0	0	0	192.02
192.03	19203	MARKETING	9	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	54	556	0	0	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	6,351	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)	2,882,202	686,769	25,539	83,485	78,998	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II Date/Time Prepared: 11/26/2019 7:45 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	ALLIED HEALTH-RAD TECH PROGRAM	
			11.00	13.00	15.00	16.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	148,010					11.00
13.00	01300	NURSING ADMINISTRATION	5,179	306,271				13.00
15.00	01500	PHARMACY	5,099	0	113,804			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	18,240		16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	437	0	0	0	25,531	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,292	115,167	0	981		30.00
31.00	03100	INTENSIVE CARE UNIT	6,167	23,447	0	286		31.00
41.00	04100	SUBPROVIDER - IRF	5,551	21,105	0	238		41.00
43.00	04300	NURSERY	2,148	8,167	0	119		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,228	61,701	0	3,159		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,509	24,747	0	436		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,596	0	0	858		54.00
54.01	03630	ULTRA SOUND	1,072	0	0	246		54.01
56.00	05600	RADIOISOTOPE	2,904	0	0	617		56.00
57.00	05700	CT SCAN	1,543	0	0	406		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,113	0	0	108		58.00
59.00	05900	CARDIAC CATHETERIZATION	146	557	0	54		59.00
60.00	06000	LABORATORY	0	0	0	2,453		60.00
65.00	06500	RESPIRATORY THERAPY	4,235	0	0	401		65.00
66.00	06600	PHYSICAL THERAPY	13,062	0	0	496		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,717	0	0	172		67.00
68.00	06800	SPEECH PATHOLOGY	705	0	0	33		68.00
69.00	06900	ELECTROCARDIOLOGY	3,253	0	0	510		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,278	0	0	231		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,805	0	0	546		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	396		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	113,020	2,099		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	23		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,379	0	0	173		76.00
76.01	03190	CHEMOTHERAPY	2,165	8,229	0	166		76.01
76.02	03330	ENDOSCOPY	137	520	0	41		76.02
76.03	03950	WOUND CARE CENTER	1,302	4,949	0	433		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,312	35,405	0	2,247		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	6,878	0	0	312		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,212	303,994	113,020	18,240	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,169	0	712	0		192.00
192.01	19201	ASC MOB	0	0	0	0		192.01
192.02	19202	EDUCATION CENTER	0	0	0	0		192.02
192.03	19203	MARKETING	0	0	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	FOUNDATION	30	0	0	0		194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0		194.01
194.02	07952	CLINIC OF HOPE	599	2,277	72	0		194.02
200.00		Cross Foot Adjustments					25,531	200.00
201.00		Negative Cost Centers	0	0	0	18,669	0	201.00
202.00		TOTAL (sum lines 118 through 201)	148,010	306,271	113,804	36,909	25,531	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B Part II Date/Time Prepared: 11/26/2019 7:45 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	891,257	0	891,257		30.00
31.00	03100	INTENSIVE CARE UNIT	226,078	0	226,078		31.00
41.00	04100	SUBPROVIDER - IRF	258,599	0	258,599		41.00
43.00	04300	NURSERY	76,059	0	76,059		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,031,753	0	1,031,753		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,483	0	186,483		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,190,634	0	1,190,634		54.00
54.01	03630	ULTRA SOUND	23,314	0	23,314		54.01
56.00	05600	RADIOISOTOPE	293,313	0	293,313		56.00
57.00	05700	CT SCAN	20,750	0	20,750		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,834	0	13,834		58.00
59.00	05900	CARDIAC CATHETERIZATION	25,285	0	25,285		59.00
60.00	06000	LABORATORY	285,227	0	285,227		60.00
65.00	06500	RESPIRATORY THERAPY	105,966	0	105,966		65.00
66.00	06600	PHYSICAL THERAPY	245,705	0	245,705		66.00
67.00	06700	OCCUPATIONAL THERAPY	81,762	0	81,762		67.00
68.00	06800	SPEECH PATHOLOGY	22,929	0	22,929		68.00
69.00	06900	ELECTROCARDIOLOGY	241,460	0	241,460		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	86,985	0	86,985		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	257,902	0	257,902		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81,527	0	81,527		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	632,681	0	632,681		73.00
74.00	07400	RENAL DIALYSIS	8,329	0	8,329		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	97,861	0	97,861		76.00
76.01	03190	CHEMOTHERAPY	253,380	0	253,380		76.01
76.02	03330	ENDOSCOPY	10,941	0	10,941		76.02
76.03	03950	WOUND CARE CENTER	72,682	0	72,682		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	468,066	0	468,066		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	282,866	0	282,866		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,473,628	0	7,473,628		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,428	0	12,428		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	378,590	0	378,590		192.00
192.01	19201	ASC MOB	10,124	0	10,124		192.01
192.02	19202	EDUCATION CENTER	448	0	448		192.02
192.03	19203	MARKETING	9	0	9		192.03
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	FOUNDATION	2,304	0	2,304		194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0		194.01
194.02	07952	CLINIC OF HOPE	9,944	0	9,944		194.02
200.00		Cross Foot Adjustments	25,531	0	25,531		200.00
201.00		Negative Cost Centers	18,669	0	18,669		201.00
202.00		TOTAL (sum lines 118 through 201)	7,931,675	0	7,931,675		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B-1 | Date/Time Prepared: 11/26/2019 7:45 am

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	331,432					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,148,309				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,820	200	31,217,989			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	50,113	20,781	2,544,225	-36,891,149	88,376,387	5.00
7.00	00700	OPERATION OF PLANT	45,990	107,049	293,175	0	4,721,174	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	518	4,768	0	0	416,452	8.00
9.00	00900	HOUSEKEEPING	2,015	0	0	0	1,590,729	9.00
10.00	01000	DIETARY	5,205	7,742	38	0	248,788	10.00
11.00	01100	CAFETERIA	6,310	17,403	0	0	1,602,001	11.00
13.00	01300	NURSING ADMINISTRATION	5,461	137,153	1,204,109	0	1,966,011	13.00
15.00	01500	PHARMACY	3,199	0	1,416,873	0	2,020,543	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	6,546	0	23,051	0	16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	896	0	320,595	0	410,202	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,444	56,712	5,049,070	0	6,903,132	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636	42,434	1,262,615	0	1,757,880	31.00
41.00	04100	SUBPROVIDER - IRF	13,568	462	988,699	0	1,425,773	41.00
43.00	04300	NURSERY	1,609	12,304	424,483	0	594,473	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,649	280,069	3,043,146	0	6,077,472	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,264	37,280	1,286,160	0	1,787,190	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,821	630,247	1,321,859	0	3,702,527	54.00
54.01	03630	ULTRA SOUND	0	6,507	289,867	0	384,222	54.01
56.00	05600	RADIOISOTOPE	2,000	179,620	635,556	0	1,309,481	56.00
57.00	05700	CT SCAN	0	1,553	360,851	0	469,872	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	270,426	0	354,759	58.00
59.00	05900	CARDIAC CATHETERIZATION	400	13,248	32,613	0	92,675	59.00
60.00	06000	LABORATORY	7,900	2,534	0	0	5,636,729	60.00
65.00	06500	RESPIRATORY THERAPY	1,237	37,079	847,029	0	1,167,964	65.00
66.00	06600	PHYSICAL THERAPY	7,215	31,143	2,241,069	0	3,080,676	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,096	4,094	775,194	0	1,087,560	67.00
68.00	06800	SPEECH PATHOLOGY	1,040	1,680	149,791	0	215,087	68.00
69.00	06900	ELECTROCARDIOLOGY	4,003	126,092	625,172	0	1,025,741	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,728	23,480	383,168	0	645,395	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	66,146	227,057	0	3,679,907	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,487,625	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	15,840,969	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	241,621	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,591	0	888,642	0	1,041,903	76.00
76.01	03190	CHEMOTHERAPY	0	54,731	416,062	0	5,341,876	76.01
76.02	03330	ENDOSCOPY	0	6,249	40,541	0	74,653	76.02
76.03	03950	WOUND CARE CENTER	3,000	0	202,203	0	874,670	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	19,340	67,229	1,748,628	0	2,842,891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,968	147,359	870,794	0	1,380,483	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	309,792	2,129,894	30,159,710	-36,868,098	84,501,106	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,029	0	0	0	8,960	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,431	10,217	921,823	0	3,645,948	192.00
192.01	19201	ASC MOB	0	7,992	0	0	9,948	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	13,732	192.02
192.03	19203	MARKETING	0	0	0	0	291	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	180	79	0	0	1,664	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	0	127	136,456	0	194,738	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)	2,886,072	2,634,378	6,818,871		36,891,149	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.707886	1.226257	0.218428		0.417432	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			111,880		2,882,202	204.00

		CAPITAL RELATED COSTS					
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
205.00	Unit cost multiplier (Wkst. B, Part II)			0.003584		0.032613	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: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B-1 | Date/Time Prepared: 11/26/2019 7:45 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MANHOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	222,509					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	518	317,519				8.00
9.00	00900	HOUSEKEEPING	2,015	97,496	195,900			9.00
10.00	01000	DIETARY	5,205	0	0	21,492		10.00
11.00	01100	CAFETERIA	6,310	0	0	0	886,409	11.00
13.00	01300	NURSING ADMINISTRATION	5,461	0	150	0	31,016	13.00
15.00	01500	PHARMACY	3,199	0	0	0	30,539	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	0	50	0	0	16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	896	0	0	0	2,618	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,444	101,403	61,340	13,735	181,409	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636	27,035	15,000	1,972	36,934	31.00
41.00	04100	SUBPROVIDER - IRF	13,568	2,656	15,000	3,935	33,245	41.00
43.00	04300	NURSERY	1,609	4,147	8,252	1,850	12,865	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,649	3,177	30,000	0	97,190	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,264	11,242	15,907	0	38,981	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,821	7,371	3,050	0	51,480	54.00
54.01	03630	ULTRA SOUND	0	2,115	650	0	6,423	54.01
56.00	05600	RADIOISOTOPE	2,000	0	2,250	0	17,389	56.00
57.00	05700	CT SCAN	0	3,483	0	0	9,243	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	926	0	0	6,668	58.00
59.00	05900	CARDIAC CATHETERIZATION	400	0	1,000	0	877	59.00
60.00	06000	LABORATORY	7,900	234	6,200	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,237	215	300	0	25,363	65.00
66.00	06600	PHYSICAL THERAPY	7,215	0	844	0	78,227	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,096	0	211	0	10,284	67.00
68.00	06800	SPEECH PATHOLOGY	1,040	199	696	0	4,221	68.00
69.00	06900	ELECTROCARDIOLOGY	4,003	0	400	0	19,480	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,728	0	2,550	0	13,645	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	5,008	5,600	0	10,810	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	35	2,250	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,000	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,591	1,789	2,000	0	32,215	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	12,963	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	819	76.02
76.03	03950	WOUND CARE CENTER	3,000	0	3,200	0	7,796	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	19,340	48,557	18,000	0	55,769	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,968	409	0	0	41,189	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	200,869	317,519	195,900	21,492	869,658	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,029	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,431	0	0	0	12,988	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	180	0	0	0	177	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	0	0	0	0	3,586	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)	6,691,943	605,871	2,501,387	509,180	2,460,500	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.074932	1.908141	12.768693	23.691606	2.775807	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	686,769	25,539	83,485	78,998	148,010	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.086477	0.080433	0.426161	3.675693	0.166977	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B-1 Date/Time Prepared: 11/26/2019 7:45 am

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MANHOURS)	
		7.00	8.00	9.00	10.00	11.00	
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 Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH-RAD TECH PROGRAM (RADIOLOGY CHARGES)		
			13.00	15.00	16.00	23.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	482,434					13.00
15.00	01500	PHARMACY	0	3,818,890				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	536,750,663			16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	0	0	0	65,734,396		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	181,409	0	28,863,786	0		30.00
31.00	03100	INTENSIVE CARE UNIT	36,934	0	8,411,005	0		31.00
41.00	04100	SUBPROVIDER - IRF	33,245	0	7,000,551	0		41.00
43.00	04300	NURSERY	12,865	0	3,509,552	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	97,190	0	93,177,259	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	38,981	0	12,837,715	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	25,248,381	25,248,380		54.00
54.01	03630	ULTRA SOUND	0	0	7,243,646	7,243,645		54.01
56.00	05600	RADIOISOTOPE	0	0	18,140,278	18,140,278		56.00
57.00	05700	CT SCAN	0	0	11,931,324	11,931,324		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	3,170,769	3,170,769		58.00
59.00	05900	CARDIAC CATHETERIZATION	877	0	1,589,497	0		59.00
60.00	06000	LABORATORY	0	0	72,158,811	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	11,789,679	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	14,598,185	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,044,557	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	974,761	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	15,003,760	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	6,783,380	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	16,063,430	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	11,641,485	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,792,608	61,730,422	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	676,258	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	5,081,935	0		76.00
76.01	03190	CHEMOTHERAPY	12,963	0	4,894,017	0		76.01
76.02	03330	ENDOSCOPY	819	0	1,196,304	0		76.02
76.03	03950	WOUND CARE CENTER	7,796	0	12,747,998	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	55,769	0	66,077,024	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	9,164,894	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	478,848	3,792,608	536,750,663	65,734,396		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	23,877	0	0		192.00
192.01	19201	ASC MOB	0	0	0	0		192.01
192.02	19202	EDUCATION CENTER	0	0	0	0		192.02
192.03	19203	MARKETING	0	0	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	FOUNDATION	0	0	0	0		194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0		194.01
194.02	07952	CLINIC OF HOPE	3,586	2,405	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)	3,038,935	3,044,962	51,180	615,647		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.299173	0.797342	0.000095	0.009366		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	306,271	113,804	36,909	25,531		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.634845	0.029800	0.000034	0.000388		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet B-1 | Date/Time Prepared: 11/26/2019 7:45 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH-RAD TECH PROGRAM (RADIOLOGY CHARGES)		
			13.00	15.00	16.00	23.00		
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I | Date/Time Prepared: 11/26/2019 7:45 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,621,395		13,621,395	0	13,621,395	30.00
31.00	03100	INTENSIVE CARE UNIT	3,286,989		3,286,989	0	3,286,989	31.00
41.00	04100	SUBPROVIDER - IRF	3,021,180		3,021,180	0	3,021,180	41.00
43.00	04300	NURSERY	1,165,208		1,165,208	0	1,165,208	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,876,482		10,876,482	0	10,876,482	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,210,920		3,210,920	0	3,210,920	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,399,258		6,399,258	0	6,399,258	54.00
54.01	03630	ULTRA SOUND	643,306		643,306	0	643,306	54.01
56.00	05600	RADIOISOTOPE	2,164,874		2,164,874	10,177	2,175,051	56.00
57.00	05700	CT SCAN	811,197		811,197	0	811,197	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	553,121		553,121	0	553,121	58.00
59.00	05900	CARDIAC CATHETERIZATION	164,269		164,269	0	164,269	59.00
60.00	06000	LABORATORY	8,313,740		8,313,740	0	8,313,740	60.00
65.00	06500	RESPIRATORY THERAPY	1,768,477	0	1,768,477	0	1,768,477	65.00
66.00	06600	PHYSICAL THERAPY	4,812,947	0	4,812,947	0	4,812,947	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,666,373	0	1,666,373	0	1,666,373	67.00
68.00	06800	SPEECH PATHOLOGY	357,226	0	357,226	0	357,226	68.00
69.00	06900	ELECTROCARDIOLOGY	1,634,913		1,634,913	0	1,634,913	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,067,928		1,067,928	0	1,067,928	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,458,204		5,458,204	0	5,458,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,527,187		3,527,187	0	3,527,187	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,512,182		25,512,182	0	25,512,182	73.00
74.00	07400	RENAL DIALYSIS	355,314		355,314	0	355,314	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,733,758		1,733,758	0	1,733,758	76.00
76.01	03190	CHEMOTHERAPY	7,689,850		7,689,850	0	7,689,850	76.01
76.02	03330	ENDOSCOPY	113,362		113,362	0	113,362	76.02
76.03	03950	WOUND CARE CENTER	1,442,829		1,442,829	0	1,442,829	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,446,124		5,446,124	0	5,446,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	901,115		901,115		901,115	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,192,062		2,192,062	0	2,192,062	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	119,911,790	0	119,911,790	10,177	119,921,967	200.00
201.00		Less Observation Beds	901,115		901,115		901,115	201.00
202.00		Total (see instructions)	119,010,675	0	119,010,675	10,177	119,020,852	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I | Date/Time Prepared: 11/26/2019 7:45 am

Title XVIII | Hospital | PPS

		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	26,858,578		26,858,578			30.00
31.00	03100	INTENSIVE CARE UNIT	8,411,005		8,411,005			31.00
41.00	04100	SUBPROVIDER - IRF	7,000,551		7,000,551			41.00
43.00	04300	NURSERY	3,509,552		3,509,552			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,423,109	65,754,150	93,177,259	0.116729	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,573,840	1,263,875	12,837,715	0.250116	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,757,299	22,491,082	25,248,381	0.253452	0.000000	54.00
54.01	03630	ULTRA SOUND	1,342,791	5,900,855	7,243,646	0.088810	0.000000	54.01
56.00	05600	RADIOISOTOPE	507,927	17,632,351	18,140,278	0.119341	0.000000	56.00
57.00	05700	CT SCAN	2,556,026	9,375,298	11,931,324	0.067989	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	664,372	2,506,397	3,170,769	0.174444	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	391,303	1,198,194	1,589,497	0.103347	0.000000	59.00
60.00	06000	LABORATORY	25,262,590	46,896,221	72,158,811	0.115214	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,983,929	3,805,750	11,789,679	0.150002	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,944,727	10,653,458	14,598,185	0.329695	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,211,291	1,833,266	5,044,557	0.330331	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	651,480	323,281	974,761	0.366475	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,463,498	12,540,262	15,003,760	0.108967	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	247,112	6,536,268	6,783,380	0.157433	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,550,679	6,512,751	16,063,430	0.339791	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,213,421	5,428,064	11,641,485	0.302984	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,376,912	47,353,510	61,730,422	0.413284	0.000000	73.00
74.00	07400	RENAL DIALYSIS	663,902	12,356	676,258	0.525412	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,107	5,076,828	5,081,935	0.341161	0.000000	76.00
76.01	03190	CHEMOTHERAPY	100,012	4,794,005	4,894,017	1.571276	0.000000	76.01
76.02	03330	ENDOSCOPY	87,566	1,108,738	1,196,304	0.094760	0.000000	76.02
76.03	03950	WOUND CARE CENTER	80,634	12,667,364	12,747,998	0.113181	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	11,844,934	54,232,090	66,077,024	0.082421	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	410,385	1,594,823	2,005,208	0.449387	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,580	9,159,314	9,164,894	0.239180	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	180,100,112	356,650,551	536,750,663			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	180,100,112	356,650,551	536,750,663			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I | Date/Time Prepared: 11/26/2019 7:45 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.116729	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250116	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.253452	54.00
54.01	03630	ULTRA SOUND	0.088810	54.01
56.00	05600	RADIOISOTOPE	0.119902	56.00
57.00	05700	CT SCAN	0.067989	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.174444	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103347	59.00
60.00	06000	LABORATORY	0.115214	60.00
65.00	06500	RESPIRATORY THERAPY	0.150002	65.00
66.00	06600	PHYSICAL THERAPY	0.329695	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330331	67.00
68.00	06800	SPEECH PATHOLOGY	0.366475	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108967	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.157433	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.339791	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302984	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413284	73.00
74.00	07400	RENAL DIALYSIS	0.525412	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.341161	76.00
76.01	03190	CHEMOTHERAPY	1.571276	76.01
76.02	03330	ENDOSCOPY	0.094760	76.02
76.03	03950	WOUND CARE CENTER	0.113181	76.03
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.082421	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.449387	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.239180	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/26/2019 7:45 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	13,621,395		13,621,395	0	13,621,395	30.00
31.00	03100	INTENSIVE CARE UNIT	3,286,989		3,286,989	0	3,286,989	31.00
41.00	04100	SUBPROVIDER - IRF	3,021,180		3,021,180	0	3,021,180	41.00
43.00	04300	NURSERY	1,165,208		1,165,208	0	1,165,208	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,876,482		10,876,482	0	10,876,482	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,210,920		3,210,920	0	3,210,920	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,399,258		6,399,258	0	6,399,258	54.00
54.01	03630	ULTRA SOUND	643,306		643,306	0	643,306	54.01
56.00	05600	RADIOISOTOPE	2,164,874		2,164,874	10,177	2,175,051	56.00
57.00	05700	CT SCAN	811,197		811,197	0	811,197	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	553,121		553,121	0	553,121	58.00
59.00	05900	CARDIAC CATHETERIZATION	164,269		164,269	0	164,269	59.00
60.00	06000	LABORATORY	8,313,740		8,313,740	0	8,313,740	60.00
65.00	06500	RESPIRATORY THERAPY	1,768,477	0	1,768,477	0	1,768,477	65.00
66.00	06600	PHYSICAL THERAPY	4,812,947	0	4,812,947	0	4,812,947	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,666,373	0	1,666,373	0	1,666,373	67.00
68.00	06800	SPEECH PATHOLOGY	357,226	0	357,226	0	357,226	68.00
69.00	06900	ELECTROCARDIOLOGY	1,634,913		1,634,913	0	1,634,913	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,067,928		1,067,928	0	1,067,928	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,458,204		5,458,204	0	5,458,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,527,187		3,527,187	0	3,527,187	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,512,182		25,512,182	0	25,512,182	73.00
74.00	07400	RENAL DIALYSIS	355,314		355,314	0	355,314	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,733,758		1,733,758	0	1,733,758	76.00
76.01	03190	CHEMOTHERAPY	7,689,850		7,689,850	0	7,689,850	76.01
76.02	03330	ENDOSCOPY	113,362		113,362	0	113,362	76.02
76.03	03950	WOUND CARE CENTER	1,442,829		1,442,829	0	1,442,829	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,446,124		5,446,124	0	5,446,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	901,115		901,115		901,115	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,192,062		2,192,062	0	2,192,062	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	119,911,790	0	119,911,790	10,177	119,921,967	200.00
201.00		Less Observation Beds	901,115		901,115		901,115	201.00
202.00		Total (see instructions)	119,010,675	0	119,010,675	10,177	119,020,852	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I | Date/Time Prepared: 11/26/2019 7:45 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	26,858,578		26,858,578			30.00
31.00	03100	INTENSIVE CARE UNIT	8,411,005		8,411,005			31.00
41.00	04100	SUBPROVIDER - IRF	7,000,551		7,000,551			41.00
43.00	04300	NURSERY	3,509,552		3,509,552			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,423,109	65,754,150	93,177,259	0.116729	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,573,840	1,263,875	12,837,715	0.250116	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,757,299	22,491,082	25,248,381	0.253452	0.000000	54.00
54.01	03630	ULTRA SOUND	1,342,791	5,900,855	7,243,646	0.088810	0.000000	54.01
56.00	05600	RADIOISOTOPE	507,927	17,632,351	18,140,278	0.119341	0.000000	56.00
57.00	05700	CT SCAN	2,556,026	9,375,298	11,931,324	0.067989	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	664,372	2,506,397	3,170,769	0.174444	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	391,303	1,198,194	1,589,497	0.103347	0.000000	59.00
60.00	06000	LABORATORY	25,262,590	46,896,221	72,158,811	0.115214	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,983,929	3,805,750	11,789,679	0.150002	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,944,727	10,653,458	14,598,185	0.329695	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,211,291	1,833,266	5,044,557	0.330331	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	651,480	323,281	974,761	0.366475	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,463,498	12,540,262	15,003,760	0.108967	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	247,112	6,536,268	6,783,380	0.157433	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,550,679	6,512,751	16,063,430	0.339791	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,213,421	5,428,064	11,641,485	0.302984	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,376,912	47,353,510	61,730,422	0.413284	0.000000	73.00
74.00	07400	RENAL DIALYSIS	663,902	12,356	676,258	0.525412	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,107	5,076,828	5,081,935	0.341161	0.000000	76.00
76.01	03190	CHEMOTHERAPY	100,012	4,794,005	4,894,017	1.571276	0.000000	76.01
76.02	03330	ENDOSCOPY	87,566	1,108,738	1,196,304	0.094760	0.000000	76.02
76.03	03950	WOUND CARE CENTER	80,634	12,667,364	12,747,998	0.113181	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	11,844,934	54,232,090	66,077,024	0.082421	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	410,385	1,594,823	2,005,208	0.449387	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,580	9,159,314	9,164,894	0.239180	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	180,100,112	356,650,551	536,750,663			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	180,100,112	356,650,551	536,750,663			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet C Part I Date/Time Prepared: 11/26/2019 7:45 am

			Title XIX	Hospital	Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.00
76.01	03190	CHEMOTHERAPY	0.000000	76.01
76.02	03330	ENDOSCOPY	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part I Date/Time Prepared: 11/26/2019 7:45 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	891,257	0	891,257	14,708	60.60	30.00
31.00	INTENSIVE CARE UNIT	226,078		226,078	1,972	114.64	31.00
41.00	SUBPROVIDER - IRF	258,599	0	258,599	3,935	65.72	41.00
43.00	NURSERY	76,059		76,059	1,850	41.11	43.00
200.00	Total (lines 30 through 199)	1,451,993		1,451,993	22,465		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	5,208	315,605	30.00
31.00	INTENSIVE CARE UNIT	960	110,054	31.00
41.00	SUBPROVIDER - IRF	2,421	159,108	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	8,589	584,767	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part II Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Hospital	PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,031,753	93,177,259	0.011073	12,466,366	138,040	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,483	12,837,715	0.014526	43,668	634	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,190,634	25,248,381	0.047157	1,292,235	60,938	54.00
54.01	03630	ULTRA SOUND	23,314	7,243,646	0.003219	488,843	1,574	54.01
56.00	05600	RADIOISOTOPE	293,313	18,140,278	0.016169	267,633	4,327	56.00
57.00	05700	CT SCAN	20,750	11,931,324	0.001739	1,146,047	1,993	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,834	3,170,769	0.004363	281,200	1,227	58.00
59.00	05900	CARDIAC CATHETERIZATION	25,285	1,589,497	0.015908	122,766	1,953	59.00
60.00	06000	LABORATORY	285,227	72,158,811	0.003953	10,252,146	40,527	60.00
65.00	06500	RESPIRATORY THERAPY	105,966	11,789,679	0.008988	3,176,109	28,547	65.00
66.00	06600	PHYSICAL THERAPY	245,705	14,598,185	0.016831	1,010,801	17,013	66.00
67.00	06700	OCCUPATIONAL THERAPY	81,762	5,044,557	0.016208	780,573	12,652	67.00
68.00	06800	SPEECH PATHOLOGY	22,929	974,761	0.023523	225,921	5,314	68.00
69.00	06900	ELECTROCARDIOLOGY	241,460	15,003,760	0.016093	1,605,725	25,841	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	86,985	6,783,380	0.012823	176,975	2,269	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	257,902	16,063,430	0.016055	3,344,749	53,700	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81,527	11,641,485	0.007003	3,877,520	27,154	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	632,681	61,730,422	0.010249	5,512,698	56,500	73.00
74.00	07400	RENAL DIALYSIS	8,329	676,258	0.012316	321,136	3,955	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	97,861	5,081,935	0.019257	0	0	76.00
76.01	03190	CHEMOTHERAPY	253,380	4,894,017	0.051773	2,961	153	76.01
76.02	03330	ENDOSCOPY	10,941	1,196,304	0.009146	37,402	342	76.02
76.03	03950	WOUND CARE CENTER	72,682	12,747,998	0.005701	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	468,066	66,077,024	0.007084	5,175,645	36,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	58,961	2,005,208	0.029404	299,130	8,796	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	5,797,730	481,806,083		51,908,249	530,113	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part III Date/Time Prepared: 11/26/2019 7:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	14,708	0.00	5,208	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,972	0.00	960	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	3,935	0.00	2,421	41.00
43.00	04300	NURSERY		0	1,850	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	22,465		8,589	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV Date/Time Prepared: 11/26/2019 7:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	236,455	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	67,844	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	169,902	56.00
57.00	05700	CT SCAN	0	0	0	0	111,749	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	29,697	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	615,647	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010

Period: From 07/01/2018 To 06/30/2019

Worksheet D Part IV

Date/Time Prepared: 11/26/2019 7:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	93,177,259	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	12,837,715	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	236,455	236,455	25,248,381	0.009365	54.00
54.01	03630	ULTRA SOUND	0	67,844	67,844	7,243,646	0.009366	54.01
56.00	05600	RADIOISOTOPE	0	169,902	169,902	18,140,278	0.009366	56.00
57.00	05700	CT SCAN	0	111,749	111,749	11,931,324	0.009366	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	29,697	29,697	3,170,769	0.009366	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,589,497	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	72,158,811	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,789,679	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	14,598,185	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,044,557	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	974,761	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,003,760	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,783,380	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	16,063,430	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,641,485	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	61,730,422	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	676,258	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	5,081,935	0.000000	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	4,894,017	0.000000	76.01
76.02	03330	ENDOSCOPY	0	0	0	1,196,304	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	12,747,998	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	66,077,024	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,005,208	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	615,647	615,647	481,806,083		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV | Date/Time Prepared: 11/26/2019 7:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	12,466,366	0	19,230,765	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	43,668	0	2,320	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.009365	1,292,235	12,102	5,500,733	51,514	54.00
54.01	03630	ULTRA SOUND	0.009366	488,843	4,579	1,646,424	15,420	54.01
56.00	05600	RADIOISOTOPE	0.009366	267,633	2,507	6,890,443	64,536	56.00
57.00	05700	CT SCAN	0.009366	1,146,047	10,734	3,105,964	29,090	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.009366	281,200	2,634	818,910	7,670	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	122,766	0	461,025	0	59.00
60.00	06000	LABORATORY	0.000000	10,252,146	0	7,442,820	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,176,109	0	226,602	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,010,801	0	73,898	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	780,573	0	27,299	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	225,921	0	5,627	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,605,725	0	6,028,869	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	176,975	0	1,684,531	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	3,344,749	0	2,254,764	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,877,520	0	1,787,842	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,512,698	0	17,928,090	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	321,136	0	2,761	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.000000	2,961	0	1,130,652	0	76.01
76.02	03330	ENDOSCOPY	0.000000	37,402	0	317,187	0	76.02
76.03	03950	WOUND CARE CENTER	0.000000	0	0	5,879,198	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	5,175,645	0	13,146,715	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	299,130	0	265,577	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		51,908,249	32,556	95,859,016	168,230	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V Date/Time Prepared: 11/26/2019 7:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.116729	19,230,765	0	0	2,244,788	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250116	2,320	0	0	580	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.253452	5,500,733	0	0	1,394,172	54.00
54.01	03630	ULTRA SOUND	0.088810	1,646,424	0	0	146,219	54.01
56.00	05600	RADIOISOTOPE	0.119341	6,890,443	0	0	822,312	56.00
57.00	05700	CT SCAN	0.067989	3,105,964	0	0	211,171	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.174444	818,910	0	0	142,854	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103347	461,025	0	0	47,646	59.00
60.00	06000	LABORATORY	0.115214	7,442,820	0	0	857,517	60.00
65.00	06500	RESPIRATORY THERAPY	0.150002	226,602	0	0	33,991	65.00
66.00	06600	PHYSICAL THERAPY	0.329695	73,898	0	0	24,364	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330331	27,299	0	0	9,018	67.00
68.00	06800	SPEECH PATHOLOGY	0.366475	5,627	0	0	2,062	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108967	6,028,869	0	0	656,948	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.157433	1,684,531	0	0	265,201	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.339791	2,254,764	0	0	766,149	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302984	1,787,842	0	0	541,688	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413284	17,928,090	0	4,097	7,409,393	73.00
74.00	07400	RENAL DIALYSIS	0.525412	2,761	0	0	1,451	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.341161	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	1.571276	1,130,652	0	0	1,776,566	76.01
76.02	03330	ENDOSCOPY	0.094760	317,187	0	0	30,057	76.02
76.03	03950	WOUND CARE CENTER	0.113181	5,879,198	0	0	665,414	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.082421	13,146,715	0	0	1,083,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.449387	265,577	0	0	119,347	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.239180		0			95.00
200.00		Subtotal (see instructions)		95,859,016	0	4,097	19,252,473	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		95,859,016	0	4,097	19,252,473	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part V Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Hospital	PPS

		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,693	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	1,693	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	1,693	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part II | Date/Time Prepared: 11/26/2019 7:45 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,031,753	93,177,259	0.011073	81,180	899	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,483	12,837,715	0.014526	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,190,634	25,248,381	0.047157	96,054	4,530	54.00
54.01	03630	ULTRA SOUND	23,314	7,243,646	0.003219	39,902	128	54.01
56.00	05600	RADIOISOTOPE	293,313	18,140,278	0.016169	16,422	266	56.00
57.00	05700	CT SCAN	20,750	11,931,324	0.001739	36,550	64	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,834	3,170,769	0.004363	4,750	21	58.00
59.00	05900	CARDIAC CATHETERIZATION	25,285	1,589,497	0.015908	0	0	59.00
60.00	06000	LABORATORY	285,227	72,158,811	0.003953	1,189,419	4,702	60.00
65.00	06500	RESPIRATORY THERAPY	105,966	11,789,679	0.008988	279,350	2,511	65.00
66.00	06600	PHYSICAL THERAPY	245,705	14,598,185	0.016831	1,190,657	20,040	66.00
67.00	06700	OCCUPATIONAL THERAPY	81,762	5,044,557	0.016208	1,053,348	17,073	67.00
68.00	06800	SPEECH PATHOLOGY	22,929	974,761	0.023523	180,032	4,235	68.00
69.00	06900	ELECTROCARDIOLOGY	241,460	15,003,760	0.016093	14,956	241	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	86,985	6,783,380	0.012823	5,566	71	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	257,902	16,063,430	0.016055	253,928	4,077	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81,527	11,641,485	0.007003	15,752	110	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	632,681	61,730,422	0.010249	567,563	5,817	73.00
74.00	07400	RENAL DIALYSIS	8,329	676,258	0.012316	90,093	1,110	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	97,861	5,081,935	0.019257	0	0	76.00
76.01	03190	CHEMOTHERAPY	253,380	4,894,017	0.051773	0	0	76.01
76.02	03330	ENDOSCOPY	10,941	1,196,304	0.009146	0	0	76.02
76.03	03950	WOUND CARE CENTER	72,682	12,747,998	0.005701	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	468,066	66,077,024	0.007084	17,644	125	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,005,208	0.000000	11,681	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	5,738,769	481,806,083		5,144,847	66,020	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV | Date/Time Prepared: 11/26/2019 7:45 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	236,455	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	67,844	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	169,902	56.00
57.00	05700	CT SCAN	0	0	0	0	111,749	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	29,697	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	615,647	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV | Date/Time Prepared: 11/26/2019 7:45 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	93,177,259	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	12,837,715	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	236,455	236,455	25,248,381	0.009365	54.00
54.01	03630	ULTRA SOUND	0	67,844	67,844	7,243,646	0.009366	54.01
56.00	05600	RADIOISOTOPE	0	169,902	169,902	18,140,278	0.009366	56.00
57.00	05700	CT SCAN	0	111,749	111,749	11,931,324	0.009366	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	29,697	29,697	3,170,769	0.009366	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,589,497	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	72,158,811	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,789,679	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	14,598,185	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,044,557	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	974,761	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,003,760	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,783,380	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	16,063,430	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,641,485	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	61,730,422	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	676,258	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	5,081,935	0.000000	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	4,894,017	0.000000	76.01
76.02	03330	ENDOSCOPY	0	0	0	1,196,304	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	12,747,998	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	66,077,024	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,005,208	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	615,647	615,647	481,806,083		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part IV
Component CCN: 15-T010 | Date/Time Prepared: 11/26/2019 7:45 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	81,180	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.009365	96,054	900	0	0	54.00
54.01	03630	ULTRA SOUND	0.009366	39,902	374	0	0	54.01
56.00	05600	RADIOISOTOPE	0.009366	16,422	154	0	0	56.00
57.00	05700	CT SCAN	0.009366	36,550	342	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.009366	4,750	44	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,189,419	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	279,350	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,190,657	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,053,348	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	180,032	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	14,956	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	5,566	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	253,928	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	15,752	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	567,563	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	90,093	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.000000	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0.000000	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	17,644	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	11,681	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		5,144,847	1,814	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V | Date/Time Prepared: 11/26/2019 7:45 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.116729	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250116	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.253452	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.088810	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.119341	0	0	0	0	56.00
57.00	05700	CT SCAN	0.067989	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.174444	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103347	0	0	0	0	59.00
60.00	06000	LABORATORY	0.115214	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.150002	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.329695	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330331	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.366475	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108967	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.157433	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.339791	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302984	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413284	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.525412	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.341161	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	1.571276	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0.094760	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.113181	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.082421	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.449387	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.239180		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V | Date/Time Prepared: 11/26/2019 7:45 am

Title XVIII | Subprovider - IRF | PPS

		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V Date/Time Prepared: 11/26/2019 7:45 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges PPS Reimbursed Services (see inst.)	Charges Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.116729	0	6,596,427	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250116	0	642,709	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.253452	0	2,964,552	0	0	54.00
54.01	03630	ULTRA SOUND	0.088810	0	753,183	0	0	54.01
56.00	05600	RADIOISOTOPE	0.119341	0	1,840,822	0	0	56.00
57.00	05700	CT SCAN	0.067989	0	1,400,149	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.174444	0	286,253	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103347	0	16,074	0	0	59.00
60.00	06000	LABORATORY	0.115214	0	8,724,486	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.150002	0	529,384	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.329695	0	1,211,821	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330331	0	159,316	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.366475	0	65,382	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108967	0	680,819	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.157433	0	970,668	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.339791	0	496,889	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302984	0	414,133	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413284	0	6,276,344	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.525412	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.341161	0	1,479,861	0	0	76.00
76.01	03190	CHEMOTHERAPY	1.571276	0	603,544	0	0	76.01
76.02	03330	ENDOSCOPY	0.094760	0	91,062	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.113181	0	1,697,738	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.082421	0	15,157,100	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.449387	0	238,804	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.239180	0	2,059,451			95.00
200.00		Subtotal (see instructions)		0	55,356,971	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	55,356,971	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D Part V Date/Time Prepared: 11/26/2019 7:45 am

Title XIX | 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	769,994	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	160,752	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	751,372	0	54.00
54.01	03630	ULTRA SOUND	66,890	0	54.01
56.00	05600	RADIOISOTOPE	219,686	0	56.00
57.00	05700	CT SCAN	95,195	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	49,935	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,661	0	59.00
60.00	06000	LABORATORY	1,005,183	0	60.00
65.00	06500	RESPIRATORY THERAPY	79,409	0	65.00
66.00	06600	PHYSICAL THERAPY	399,531	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,627	0	67.00
68.00	06800	SPEECH PATHOLOGY	23,961	0	68.00
69.00	06900	ELECTROCARDIOLOGY	74,187	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	152,815	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	168,838	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	125,476	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,593,913	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	504,871	0	76.00
76.01	03190	CHEMOTHERAPY	948,334	0	76.01
76.02	03330	ENDOSCOPY	8,629	0	76.02
76.03	03950	WOUND CARE CENTER	192,152	0	76.03
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,249,263	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	107,315	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	492,579		95.00
200.00		Subtotal (see instructions)	10,294,568	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	10,294,568	0	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Hospital	PPS

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,708	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,708	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	13,735	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,208	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,621,395	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13,621,395	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)	13,621,395	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)	926.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,823,233	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)	4,823,233	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Hospital	PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,286,989	1,972	1,666.83	960	1,600,157	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)	9,870,722	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	16,294,112	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)	425,659	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	562,669	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	988,328	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	15,305,784	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)	973	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	926.12	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	901,115	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	891,257	13,621,395	0.065431	901,115	58,961	90.00
91.00	Nursing School cost	0	13,621,395	0.000000	901,115	0	91.00
92.00	Allied health cost	0	13,621,395	0.000000	901,115	0	92.00
93.00	All other Medical Education	0	13,621,395	0.000000	901,115	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,935	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,935	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)	3,935	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,421	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,021,180	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,021,180	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)	3,021,180	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)	767.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,858,771	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)	1,858,771	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,410,238	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,269,009	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)	159,108	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	67,834	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	226,942	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,042,067	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	258,599	3,021,180	0.085595	0	0	90.00
91.00	Nursing School cost	0	3,021,180	0.000000	0	0	91.00
92.00	Allied health cost	0	3,021,180	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,021,180	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/26/2019 7:45 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)	14,708	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,708	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	13,735	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	325	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)	1,850	15.00
16.00	Nursery days (title V or XIX only)	189	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,621,395	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13,621,395	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)	13,621,395	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)	926.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	300,989	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)	300,989	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/26/2019 7:45 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)	1,165,208	1,850	629.84	189	119,040	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,286,989	1,972	1,666.83	210	350,034	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,970,957	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,741,020	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)	973	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	926.12	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	901,115	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-1 | Date/Time Prepared: 11/26/2019 7:45 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	891,257	13,621,395	0.065431	901,115	58,961	90.00
91.00	Nursing School cost	0	13,621,395	0.000000	901,115	0	91.00
92.00	Allied health cost	0	13,621,395	0.000000	901,115	0	92.00
93.00	All other Medical Education	0	13,621,395	0.000000	901,115	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Hospital	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,371,790		30.00
31.00	03100	INTENSIVE CARE UNIT		3,905,718		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.116729	12,466,366	1,455,186	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250116	43,668	10,922	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.253452	1,292,235	327,520	54.00
54.01	03630	ULTRA SOUND	0.088810	488,843	43,414	54.01
56.00	05600	RADIOISOTOPE	0.119902	267,633	32,090	56.00
57.00	05700	CT SCAN	0.067989	1,146,047	77,919	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.174444	281,200	49,054	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103347	122,766	12,687	59.00
60.00	06000	LABORATORY	0.115214	10,252,146	1,181,191	60.00
65.00	06500	RESPIRATORY THERAPY	0.150002	3,176,109	476,423	65.00
66.00	06600	PHYSICAL THERAPY	0.329695	1,010,801	333,256	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330331	780,573	257,847	67.00
68.00	06800	SPEECH PATHOLOGY	0.366475	225,921	82,794	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108967	1,605,725	174,971	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.157433	176,975	27,862	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.339791	3,344,749	1,136,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302984	3,877,520	1,174,827	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413284	5,512,698	2,278,310	73.00
74.00	07400	RENAL DIALYSIS	0.525412	321,136	168,729	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.341161	0	0	76.00
76.01	03190	CHEMOTHERAPY	1.571276	2,961	4,653	76.01
76.02	03330	ENDOSCOPY	0.094760	37,402	3,544	76.02
76.03	03950	WOUND CARE CENTER	0.113181	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.082421	5,175,645	426,582	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.449387	299,130	134,425	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		51,908,249	9,870,722	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)		51,908,249		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		4,252,619		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.116729	81,180	9,476	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250116	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.253452	96,054	24,345	54.00
54.01	03630	ULTRA SOUND	0.088810	39,902	3,544	54.01
56.00	05600	RADIOISOTOPE	0.119902	16,422	1,969	56.00
57.00	05700	CT SCAN	0.067989	36,550	2,485	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.174444	4,750	829	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103347	0	0	59.00
60.00	06000	LABORATORY	0.115214	1,189,419	137,038	60.00
65.00	06500	RESPIRATORY THERAPY	0.150002	279,350	41,903	65.00
66.00	06600	PHYSICAL THERAPY	0.329695	1,190,657	392,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330331	1,053,348	347,953	67.00
68.00	06800	SPEECH PATHOLOGY	0.366475	180,032	65,977	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108967	14,956	1,630	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.157433	5,566	876	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.339791	253,928	86,282	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302984	15,752	4,773	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413284	567,563	234,565	73.00
74.00	07400	RENAL DIALYSIS	0.525412	90,093	47,336	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.341161	0	0	76.00
76.01	03190	CHEMOTHERAPY	1.571276	0	0	76.01
76.02	03330	ENDOSCOPY	0.094760	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.113181	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.082421	17,644	1,454	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.449387	11,681	5,249	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,144,847	1,410,238	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)		5,144,847		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/26/2019 7:45 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		4,974,066		30.00
31.00	03100	INTENSIVE CARE UNIT		942,620		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		1,785,489		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.116729	3,121,824	364,407	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250116	5,409,930	1,353,110	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.253452	275,832	69,910	54.00
54.01	03630	ULTRA SOUND	0.088810	146,853	13,042	54.01
56.00	05600	RADIOISOTOPE	0.119341	57,938	6,914	56.00
57.00	05700	CT SCAN	0.067989	287,231	19,529	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.174444	74,710	13,033	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103347	48,248	4,986	59.00
60.00	06000	LABORATORY	0.115214	3,790,984	436,774	60.00
65.00	06500	RESPIRATORY THERAPY	0.150002	856,602	128,492	65.00
66.00	06600	PHYSICAL THERAPY	0.329695	219,535	72,380	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330331	28,862	9,534	67.00
68.00	06800	SPEECH PATHOLOGY	0.366475	11,845	4,341	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108967	272,806	29,727	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.157433	22,875	3,601	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.339791	781,366	265,501	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302984	508,337	154,018	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413284	2,061,449	851,964	73.00
74.00	07400	RENAL DIALYSIS	0.525412	3,244	1,704	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.341161	319	109	76.00
76.01	03190	CHEMOTHERAPY	1.571276	17,555	27,584	76.01
76.02	03330	ENDOSCOPY	0.094760	6,720	637	76.02
76.03	03950	WOUND CARE CENTER	0.113181	4,076	461	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.082421	1,688,872	139,199	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.449387	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		19,698,013	3,970,957	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)		19,698,013		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet D-3 | Date/Time Prepared: 11/26/2019 7:45 am

Title XIX | Subprovider - IRF | 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
41.00	04100	SUBPROVIDER - IRF		368,754		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.116729	16,845	1,966	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250116	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.253452	4,011	1,017	54.00
54.01	03630	ULTRA SOUND	0.088810	0	0	54.01
56.00	05600	RADIOISOTOPE	0.119341	0	0	56.00
57.00	05700	CT SCAN	0.067989	2,633	179	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.174444	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103347	0	0	59.00
60.00	06000	LABORATORY	0.115214	108,784	12,533	60.00
65.00	06500	RESPIRATORY THERAPY	0.150002	56,005	8,401	65.00
66.00	06600	PHYSICAL THERAPY	0.329695	170,096	56,080	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330331	22,362	7,387	67.00
68.00	06800	SPEECH PATHOLOGY	0.366475	9,177	3,363	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108967	2,794	304	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.157433	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.339791	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302984	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413284	47,291	19,545	73.00
74.00	07400	RENAL DIALYSIS	0.525412	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.341161	0	0	76.00
76.01	03190	CHEMOTHERAPY	1.571276	0	0	76.01
76.02	03330	ENDOSCOPY	0.094760	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.113181	12,588	1,425	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.082421	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.449387	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		452,586	112,200	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)		452,586		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	3,083,576	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	9,561,543	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	237,983	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	116.33	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.30	30.00
31.00	Percentage of Medicaid patient days (see instructions)	24.02	31.00
32.00	Sum of lines 30 and 31	27.32	32.00
33.00	Allowable disproportionate share percentage (see instructions)	11.75	33.00
34.00	Disproportionate share adjustment (see instructions)	371,450	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E Part A Date/Time Prepared: 11/26/2019 7:45 am

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000136154	0.000155566	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	921,313	1,286,977	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	232,222	962,588	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,194,810		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	14,449,362		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	14,449,362	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,090,602	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	31,194	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	32,556	58.00
59.00	Total (sum of amounts on lines 49 through 58)	15,603,714	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	15,603,714	61.00
62.00	Deductibles billed to program beneficiaries	1,485,836	62.00
63.00	Coinsurance billed to program beneficiaries	7,478	63.00
64.00	Allowable bad debts (see instructions)	38,730	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	25,175	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	21,904	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	14,135,575	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	28,718	70.93
70.94	HRR adjustment amount (see instructions)	-28,006	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E Part A Date/Time Prepared: 11/26/2019 7:45 am

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Line	Description	FFY (yyyy) 0	Amount 1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		14,136,287	71.00
71.01	Sequestration adjustment (see instructions)		282,726	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		13,643,721	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		209,840	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,382,168	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

		Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,083,576	0	3,083,576		3,083,576	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,561,543	0		9,561,543	9,561,543	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	237,983	0	0	237,983	237,983	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1175	0.1175	0.1175	0.1175		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	371,450	0	90,580	280,870	371,450	11.00
11.01	Uncompensated care payments	36.00	1,194,810	0	232,222	962,588	1,194,810	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	14,449,362	0	3,406,378	11,042,984	14,449,362	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,449,362	0	3,406,378	11,042,984	14,449,362	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,090,602	0	266,217	824,385	1,090,602	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Hospital	PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,672,595	11,867,369	15,539,964	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,024,145	0	250,167	773,978	1,024,145	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	8,183	0	1,815	6,368	8,183	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0569	0.0569	0.0569	0.0569		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	58,274	0	14,235	44,039	58,274	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,090,602	0	266,217	824,385	1,090,602	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/26/2019 7:45 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,083,576	3,083,576		3,083,576	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,561,543		9,561,543	9,561,543	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	237,983	0	237,983	237,983	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1175	0.1175	0.1175		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	371,450	90,580	280,870	371,450	11.00
11.01	Uncompensated care payments	36.00	1,194,810	232,222	962,588	1,194,810	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	14,449,362	3,406,378	11,042,984	14,449,362	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,449,362	3,406,378	11,042,984	14,449,362	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,090,602	266,217	824,385	1,090,602	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			3,672,595	11,867,369	15,539,964	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/26/2019 7:45 am

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,024,145	250,167	773,978	1,024,145	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	8,183	1,815	6,368	8,183	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0569	0.0569	0.0569		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	58,274	14,235	44,039	58,274	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,090,602	266,217	824,385	1,090,602	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	28,718	3,063	25,655	28,718	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-28,006	-1,234	-26,772	-28,006	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,693	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	19,084,243	2.00
3.00	OPPS payments	17,056,918	3.00
4.00	Outlier payment (see instructions)	177,092	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	168,230	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,693	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	4,097	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)	4,097	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)	4,097	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,404	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	1,693	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)	17,402,240	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,229,924	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)	14,174,009	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)	14,174,009	30.00
31.00	Primary payer payments	1,349	31.00
32.00	Subtotal (line 30 minus line 31)	14,172,660	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)	162,160	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	105,404	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	138,578	36.00
37.00	Subtotal (see instructions)	14,278,064	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)	14,278,064	40.00
40.01	Sequestration adjustment (see instructions)	285,561	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	14,144,858	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-152,355	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	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)	0	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)	0	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)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	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)	0	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)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	0	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)	0	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	0	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	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: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet E-1 Part I Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Hospital	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		13,643,721		14,144,858	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)		13,643,721		14,144,858	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		209,840		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		152,355	6.02
7.00	Total Medicare program liability (see instructions)		13,853,561		13,992,503	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: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet E-1 Part I | Date/Time Prepared: 11/26/2019 7:45 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,807,268		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)		3,807,268		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		6,871		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,814,139		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: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet E-1 Part II Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part III Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	3,823,209	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	90,992	3.00
4.00	Outlier Payments	35,093	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	10.780822	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	3,949,294	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	3,949,294	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	3,949,294	19.00
20.00	Deductibles	54,032	20.00
21.00	Subtotal (line 19 minus line 20)	3,895,262	21.00
22.00	Coinsurance	5,097	22.00
23.00	Subtotal (line 21 minus line 22)	3,890,165	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	3,890,165	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	1,814	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	3,891,979	32.00
32.01	Sequestration adjustment (see instructions)	77,840	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	3,807,268	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	6,871	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	35,093	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2019 7:45 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	4,741,020		1.00
2.00	Medical and other services		10,294,568	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	4,741,020	10,294,568	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	4,741,020	10,294,568	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	9,746,281		8.00
9.00	Ancillary service charges	19,698,013	55,356,971	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)	29,444,294	55,356,971	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)	29,444,294	55,356,971	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	24,703,274	45,062,403	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	4,741,020	10,294,568	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	4,741,020	10,294,568	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	4,741,020	10,294,568	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	4,741,020	10,294,568	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	4,741,020	10,294,568	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	4,741,020	10,294,568	40.00
41.00	Interim payments	4,741,020	10,294,568	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2019 7:45 am
	Title XIX	Subprovider - IRF	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	0		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)	0	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)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	6,924,209		8.00
9.00	Ancillary service charges	452,586	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)	7,376,795	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)	7,376,795	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	7,376,795	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)	0	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)	0	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)	0	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)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G | Date/Time Prepared: 11/26/2019 7:45 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	1,275	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	36,642,191	0	0	0	4.00
5.00	Other receivable	1,037,080	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,207,194	0	0	0	6.00
7.00	Inventory	1,721,260	0	0	0	7.00
8.00	Prepaid expenses	39,744	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	5,325,766	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	31,560,122	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	722,779	0	0	0	12.00
13.00	Land improvements	1,764,978	0	0	0	13.00
14.00	Accumulated depreciation	-1,510,156	0	0	0	14.00
15.00	Buildings	78,936,776	0	0	0	15.00
16.00	Accumulated depreciation	-55,821,258	0	0	0	16.00
17.00	Leasehold improvements	650,869	0	0	0	17.00
18.00	Accumulated depreciation	-565,592	0	0	0	18.00
19.00	Fixed equipment	21,765,515	0	0	0	19.00
20.00	Accumulated depreciation	-20,823,856	0	0	0	20.00
21.00	Automobiles and trucks	1,005,874	0	0	0	21.00
22.00	Accumulated depreciation	-813,907	0	0	0	22.00
23.00	Major movable equipment	45,209,973	0	0	0	23.00
24.00	Accumulated depreciation	-36,439,813	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)	34,082,182	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)	65,642,304	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	8,098,832	0	0	0	37.00
38.00	Salaries, wages, and fees payable	241,721	0	0	0	38.00
39.00	Payroll taxes payable	2,555,569	0	0	0	39.00
40.00	Notes and loans payable (short term)	266,937	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	21,619,503	0	0	0	43.00
44.00	Other current liabilities	89,929	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	32,872,491	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	17,138,797	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	17,138,797	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	50,011,288	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	15,631,016				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)	15,631,016	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	65,642,304	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G-1 Date/Time Prepared: 11/26/2019 7:45 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		9,424,717		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		26,714,351				2.00
3.00	Total (sum of line 1 and line 2)		36,139,068		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)		36,139,068		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	INTERCOMPANY TRANSFERS	20,508,055		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)		20,508,055		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,631,013		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	INTERCOMPANY TRANSFERS		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: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/26/2019 7:45 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	32,235,112		32,235,112	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	7,021,699		7,021,699	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)	39,256,811		39,256,811	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	8,363,733		8,363,733	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)	8,363,733		8,363,733	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	47,620,544		47,620,544	17.00
18.00	Ancillary services	132,987,705	0	132,987,705	18.00
19.00	Outpatient services	0	357,506,037	357,506,037	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	111,611	111,611	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	180,608,249	357,617,648	538,225,897	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		134,506,409		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)		134,506,409		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2018 To 06/30/2019 | Worksheet G-3

Date/Time Prepared: 11/26/2019 7:45 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	538,225,897	1.00
2.00	Less contractual allowances and discounts on patients' accounts	378,107,583	2.00
3.00	Net patient revenues (line 1 minus line 2)	160,118,314	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	134,506,409	4.00
5.00	Net income from service to patients (line 3 minus line 4)	25,611,905	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	30,116	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	452,985	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	52,142	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	6,470	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	137,173	22.00
23.00	Governmental appropriations	-1,893	23.00
24.00	MISCELLANEOUS INCOME	142,187	24.00
24.01	ASPR BIOTERRORISM GRANT	15,601	24.01
24.02	MEALS ON WHEELS REVENUE	31,308	24.02
24.03	INTERCOMPANY RENTAL INCOME	167,991	24.03
24.04	CONTRACT SERVICE REVENUE	53,667	24.04
24.05	OTHER	14,699	24.05
25.00	Total other income (sum of lines 6-24)	1,102,446	25.00
26.00	Total (line 5 plus line 25)	26,714,351	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
27.01	RESTRICTED DONATIONS	0	27.01
27.02	DONATIONS	0	27.02
27.03	OTHER EXPENSES (SPECIFY)	0	27.03
27.04	IMPAIRMENT RESTRUCTURING AND NONRECU	0	27.04
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	26,714,351	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0010	Period: From 07/01/2018 To 06/30/2019	Worksheet L Parts I-III Date/Time Prepared: 11/26/2019 7:45 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,024,145	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	8,183	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	44.73	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	3.30	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	24.02	8.00
9.00	Sum of lines 7 and 8	27.32	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.69	10.00
11.00	Disproportionate share adjustment (see instructions)	58,274	11.00
12.00	Total prospective capital payments (see instructions)	1,090,602	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00