This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/24/2019 2:03 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/24/2019 Time: 2:03 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WITHAM MEMORIAL HOSPITAL (15-0104) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	49,616	185,560	0	-308,229	1.00
2.00	Subprovider - IPF	0	2,836	-629		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	5,593	-573		0	7.00
200.00	Total	0	58,045	184,358	0	-308,229	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: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2019 2:03 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2605 N. LEBANON STREET	PO Box:			1.00
2.00	City: LEBANON	State: IN	Zip Code: 46052-	County: BOONE	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	WITHAM MEMORIAL HOSPITAL	150104	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	WITHAM HOSPITAL GEROPSYCH	15S104	26900	4	01/01/2000	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	WITHAM HOSPITAL ECU	155832	26900		05/07/2015	N	P	N	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	9		21.00

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

		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.	184	1,221	0	0	602	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2019 2:03 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/24/2019 2:03 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/24/2019 2:03 pm

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

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

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

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

Line	Description	1.00	2.00	Line
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

Line	Description	1.00	2.00	3.00	Line
	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

Line	Description	Premiums 1.00	Losses 2.00	Insurance 3.00	Line
118.01	List amounts of malpractice premiums and paid losses:	210,978	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2019 2:03 pm

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

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2017	09/30/2017	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2019 2:03 pm

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

		Y/N	Date	
		1.00	2.00	
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/15/2019	Y	01/15/2019	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/24/2019 2:03 pm

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

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/24/2019 2:03 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2019 2:03 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	60	21,900	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)		60	21,900	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	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)		68	24,820	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY	44.00	18	6,570		0	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)		96				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2019 2:03 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,263	105	5,466			1.00
2.00	HMO and other (see instructions)	1,109	1,799				2.00
3.00	HMO IPF Subprovider	26	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,263	105	5,466			7.00
8.00	INTENSIVE CARE UNIT	834	20	1,776			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		58	1,060			13.00
14.00	Total (see instructions)	3,097	183	8,302	0.00	899.63	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,558	0	3,133	0.00	30.71	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	2,994	0	5,027	0.00	30.03	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	960.37	27.00
28.00	Observation Bed Days		0	1,546			28.00
29.00	Ambulance Trips	1,716					29.00
30.00	Employee discount days (see instruction)			167			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	25	42			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: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2019 2:03 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	873	43	2,316	1.00
2.00	HMO and other (see instructions)			303	427		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	873	43	2,316	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	183	0	230	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					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: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2019 2:03 pm

		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	60,233,427	1,087,444	61,320,871	1,633,598.00	37.54	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	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	975,379	23,078	998,457	39,245.00	25.44	9.00
10.00	Excluded area salaries (see instructions)		28,808,807	86,288	28,895,095	627,424.00	46.05	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,462,596	0	1,462,596	20,000.00	73.13	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		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		9,203,898	0	9,203,898			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		7,044,882	0	7,044,882			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	871,741	15,979	887,720	13,828.00	64.20	26.00
27.00	Administrative & General	5.00	6,248,119	339,679	6,587,798	197,156.00	33.41	27.00

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		1,518,631	0	1,518,631	9,226.00	164.60	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	661,018	21,185	682,203	23,243.00	29.35	30.00
31.00	Laundry & Linen Service	8.00	28,044	671	28,715	2,144.00	13.39	31.00
32.00	Housekeeping	9.00	452,393	8,041	460,434	31,234.00	14.74	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	875,108	-180,116	694,992	35,474.00	19.59	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	201,548	201,548	12,621.00	15.97	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	813,103	17,866	830,969	19,867.00	41.83	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	662,895	12,883	675,778	19,600.00	34.48	40.00
41.00	Medical Records & Medical Records Library	16.00	1,309,734	32,575	1,342,309	48,743.00	27.54	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: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part III Date/Time Prepared: 5/24/2019 2:03 pm

		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)		61,752,058	1,087,444	62,839,502	1,642,824.00	38.25	1.00
2.00	Excluded area salaries (see instructions)		29,784,186	109,366	29,893,552	666,669.00	44.84	2.00
3.00	Subtotal salaries (line 1 minus line 2)		31,967,872	978,078	32,945,950	976,155.00	33.75	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,462,596	0	1,462,596	20,000.00	73.13	4.00
5.00	Subtotal wage-related costs (see inst.)		9,203,898	0	9,203,898	0.00	27.94	5.00
6.00	Total (sum of lines 3 thru 5)		42,634,366	978,078	43,612,444	996,155.00	43.78	6.00
7.00	Total overhead cost (see instructions)		13,440,786	470,311	13,911,097	413,136.00	33.67	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 5/24/2019 2:03 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,630,710	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	7,612,992	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	2,463,151	9.00
10.00	Dental, Hearing and Vision Plan	481,250	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	84,623	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	220,873	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	402,822	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	2,275,413	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	76,946	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	16,248,780	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE COST	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V | Date/Time Prepared: 5/24/2019 2:03 pm

	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	1,462,596	16,248,780	1.00
2.00	Hospital	1,462,596	16,248,780	2.00
3.00	Subprovider - IPF	0	0	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	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet S-7 Date/Time Prepared: 5/24/2019 2:03 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	47	0	47	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	16	0	16	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	62	0	62	12.00
13.00		RUB	111	0	111	13.00
14.00		RUA	68	0	68	14.00
15.00		RVC	503	0	503	15.00
16.00		RVB	647	0	647	16.00
17.00		RVA	492	0	492	17.00
18.00		RHC	345	0	345	18.00
19.00		RHB	285	0	285	19.00
20.00		RHA	163	0	163	20.00
21.00		RMC	41	0	41	21.00
22.00		RMB	44	0	44	22.00
23.00		RMA	39	0	39	23.00
24.00		RLB	4	0	4	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	14	0	14	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	14	0	14	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	6	0	6	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	3	0	3	39.00
40.00		LD1	14	0	14	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	3	0	3	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	9	0	9	47.00
48.00		CD1	8	0	8	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	21	0	21	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	6	0	6	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	24	0	24	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-7 | Date/Time Prepared: 5/24/2019 2:03 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	4	0	4	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	1	0	1	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		2,994	0	2,994	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	26900	26900	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	975,379	35.03	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	SNF OTHER EXPENSE	771,268	27.70	Y	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2,784,782			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/24/2019 2:03 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.192275	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,100,304	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	44,213,921	6.00
7.00	Medicaid cost (line 1 times line 6)	8,501,232	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)	400,928	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)	400,928	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)	3,972,633	905,401	4,878,034	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	763,838	905,401	1,669,239	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)	763,838	905,401	1,669,239	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)	8,887,349	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	254,445	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	391,453	27.01
28.00	Non-Medicare bad debt expense (see instructions)	8,495,896	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,770,556	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,439,795	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,840,723	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/24/2019 2:03 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		3,822,999	3,822,999	-29,515	3,793,484	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	4,187,247	4,187,247	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	871,741	14,138,936	15,010,677	-678,000	14,332,677	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,248,119	11,838,082	18,086,201	-1,008,519	17,077,682	5.00
7.00	00700	OPERATION OF PLANT	661,018	2,593,827	3,254,845	-98,894	3,155,951	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,044	294,166	322,210	510	322,720	8.00
9.00	00900	HOUSEKEEPING	452,393	333,140	785,533	4,389	789,922	9.00
10.00	01000	DIETARY	875,108	1,022,558	1,897,666	-486,935	1,410,731	10.00
11.00	01100	CAFETERIA	0	0	0	480,775	480,775	11.00
13.00	01300	NURSING ADMINISTRATION	813,103	115,149	928,252	-26,093	902,159	13.00
15.00	01500	PHARMACY	662,895	9,209,754	9,872,649	-2,310,505	7,562,144	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,309,734	399,733	1,709,467	25,276	1,734,743	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,507,808	1,350,029	4,857,837	-301,035	4,556,802	30.00
31.00	03100	INTENSIVE CARE UNIT	1,124,754	552,904	1,677,658	-103,622	1,574,036	31.00
40.00	04000	SUBPROVIDER - IPF	1,092,438	170,862	1,263,300	-3,234	1,260,066	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	48,430	48,430	-759	47,671	43.00
44.00	04400	SKILLED NURSING FACILITY	975,379	771,268	1,746,647	-80,257	1,666,390	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,200,983	6,811,555	9,012,538	-6,173,305	2,839,233	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,478,145	4,214,492	5,692,637	-338,529	5,354,108	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	310,000	329,173	639,173	-73,475	565,698	55.01
57.00	05700	CT SCAN	196,755	1,091,149	1,287,904	-413,463	874,441	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	318,296	763,251	1,081,547	-314,342	767,205	58.00
59.00	05900	CARDIAC CATHETERIZATION	286,334	1,806,348	2,092,682	-835,973	1,256,709	59.00
60.00	06000	LABORATORY	2,649,220	4,492,093	7,141,313	-187,492	6,953,821	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	171,112	171,112	-1,537	169,575	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,757,498	278,441	2,035,939	29,802	2,065,741	66.00
67.00	06700	OCCUPATIONAL THERAPY	356,844	34,296	391,140	8,794	399,934	67.00
67.01	06701	AUDIOLOGY	205,031	214,979	420,010	-6,348	413,662	67.01
68.00	06800	SPEECH PATHOLOGY	172,741	23,916	196,657	3,592	200,249	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	1,056,745	310,878	1,367,623	-103,893	1,263,730	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-4,930	-4,930	2,921,912	2,916,982	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,754,083	4,754,083	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,236,856	2,236,856	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	193,305	85,315	278,620	-1,149	277,471	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	1,728	1,728	0	1,728	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	1,351	1,351	-1,074	277	90.05
90.07	09007	UROLOGY CLINIC	0	2,082	2,082	-1,315	767	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	3,286	8,543	11,829	2,829	14,658	90.09
90.11	09011	NEUROLOGY CLINIC	0	8,480	8,480	0	8,480	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	40,436	40,436	-33,236	7,200	90.12
90.13	09013	ALLERGY CLINIC	103,472	41,396	144,868	1,015	145,883	90.13
90.14	09014	WOUND CARE	251,339	351,990	603,329	-242,520	360,809	90.14
91.00	09100	EMERGENCY	2,354,530	3,448,578	5,803,108	-391,128	5,411,980	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,262,639	574,956	2,837,595	-123,501	2,714,094	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,779,697	71,763,445	106,543,142	287,432	106,830,574	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,123,550	9,692,164	34,815,714	-283,124	34,532,590	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB	71,491	104,169	175,660	-1,191	174,469	194.02
194.03	07953	RETAIL PHARMACY	258,689	1,173,747	1,432,436	-3,117	1,429,319	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	60,233,427	82,733,525	142,966,952	0	142,966,952	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/24/2019 2:03 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-497,315	3,296,169	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	4,187,247	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,341,347	9,991,330	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,308,249	12,769,433	5.00
7.00	00700	OPERATION OF PLANT	-925	3,155,026	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	322,720	8.00
9.00	00900	HOUSEKEEPING	0	789,922	9.00
10.00	01000	DIETARY	-352,955	1,057,776	10.00
11.00	01100	CAFETERIA	0	480,775	11.00
13.00	01300	NURSING ADMINISTRATION	0	902,159	13.00
15.00	01500	PHARMACY	-94	7,562,050	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-477	1,734,266	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	4,556,802	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,574,036	31.00
40.00	04000	SUBPROVIDER - IPF	0	1,260,066	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	47,671	43.00
44.00	04400	SKILLED NURSING FACILITY	-5,800	1,660,590	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	2,839,233	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-380,522	4,973,586	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501	ULTRA SOUND	0	565,698	55.01
57.00	05700	CT SCAN	0	874,441	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	767,205	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,256,709	59.00
60.00	06000	LABORATORY	-251,000	6,702,821	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	169,575	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	2,065,741	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	399,934	67.00
67.01	06701	AUDIOLOGY	-253,367	160,295	67.01
68.00	06800	SPEECH PATHOLOGY	0	200,249	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIOLOGY	0	1,263,730	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-51,758	2,865,224	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,754,083	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,236,856	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	277,471	90.01
90.02	09002	CLINIC	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	-1,728	0	90.03
90.04	09004	ENT CLINIC	0	0	90.04
90.05	09005	SURGERY CLINIC	-277	0	90.05
90.07	09007	UROLOGY CLINIC	-767	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	-14,658	0	90.09
90.11	09011	NEUROLOGY CLINIC	-8,480	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	-7,200	0	90.12
90.13	09013	ALLERGY CLINIC	0	145,883	90.13
90.14	09014	WOUND CARE	-40,292	320,517	90.14
91.00	09100	EMERGENCY	-2,602,200	2,809,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	-3,852	2,710,242	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,123,263	93,707,311	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	34,532,590	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	194.01
194.02	07952	OTHER NONREIMB	0	174,469	194.02
194.03	07953	RETAIL PHARMACY	0	1,429,319	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,123,263	129,843,689	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	402,439	1.00
	TOTALS		0	402,439	
	B - INSURANCE RECLASS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	156,080	1.00
	TOTALS		0	156,080	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	201,548	279,227	1.00
	TOTALS		201,548	279,227	
	D - MME DEPRECIATION				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	4,187,247	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
	TOTALS		0	4,187,247	
	E - DRUGS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,298,923	1.00
	TOTALS		0	2,298,923	
	F - MED SUPPLY IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	4,754,083	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	TOTALS		0	4,754,083	
	G - CHARGABLE MED SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,935,015	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
	TOTALS		0	2,935,015	
	H - BONUS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	15,979	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	339,679	0	2.00
3.00	OPERATION OF PLANT	7.00	21,185	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	671	0	4.00
5.00	HOUSEKEEPING	9.00	8,041	0	5.00
6.00	DIETARY	10.00	21,432	0	6.00
7.00	NURSING ADMINISTRATION	13.00	17,866	0	7.00
8.00	PHARMACY	15.00	12,883	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	32,575	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	82,305	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	36,306	0	11.00
12.00	SUBPROVIDER - IPF	40.00	30,896	0	12.00
13.00	SKILLED NURSING FACILITY	44.00	23,078	0	13.00
14.00	OPERATING ROOM	50.00	56,483	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	53,006	0	15.00
16.00	ULTRA SOUND	55.01	7,858	0	16.00
17.00	CT SCAN	57.00	6,818	0	17.00
18.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	10,809	0	18.00
19.00	CARDIAC CATHETERIZATION	59.00	5,970	0	19.00
20.00	LABORATORY	60.00	66,886	0	20.00
21.00	PHYSICAL THERAPY	66.00	49,160	0	21.00
22.00	OCCUPATIONAL THERAPY	67.00	9,343	0	22.00
23.00	AUDIOLOGY	67.01	4,466	0	23.00
24.00	SPEECH PATHOLOGY	68.00	3,593	0	24.00
25.00	CARDIOLOGY	69.01	30,968	0	25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	6,412	0	26.00
27.00	GASTROENTEROLOGY CLINIC	90.09	2,829	0	27.00
28.00	ALLERGY CLINIC	90.13	1,886	0	28.00
29.00	WOUND CARE	90.14	9,941	0	29.00
30.00	EMERGENCY	91.00	62,728	0	30.00
31.00	AMBULANCE SERVICES	95.00	55,392	0	31.00
	TOTALS		1,087,444	0	
500.00	Grand Total: Increases		1,288,992	15,013,014	500.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	402,439	0		1.00
	TOTALS		0	402,439			
	B - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	156,080	12		1.00
	TOTALS		0	156,080			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	201,548	279,227	0		1.00
	TOTALS		201,548	279,227			
	D - MME DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	185,595	9		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,912	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	777,548	0		3.00
4.00	OPERATION OF PLANT	7.00	0	120,043	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	160	0		5.00
6.00	HOUSEKEEPING	9.00	0	2,410	0		6.00
7.00	DIETARY	10.00	0	27,123	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	43,958	0		8.00
9.00	PHARMACY	15.00	0	2,191	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	7,239	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	156,200	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	37,173	0		12.00
13.00	SUBPROVIDER - IPF	40.00	0	8,525	0		13.00
14.00	SKILLED NURSING FACILITY	44.00	0	62,555	0		14.00
15.00	OPERATING ROOM	50.00	0	532,812	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	330,565	0		16.00
17.00	ULTRA SOUND	55.01	0	72,184	0		17.00
18.00	CT SCAN	57.00	0	405,185	0		18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	320,751	0		19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	171,384	0		20.00
21.00	LABORATORY	60.00	0	235,143	0		21.00
22.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	1,537	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	18,207	0		23.00
24.00	OCCUPATIONAL THERAPY	67.00	0	406	0		24.00
25.00	AUDIOLOGY	67.01	0	10,803	0		25.00
26.00	CARDIOLOGY	69.01	0	121,662	0		26.00
27.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	5,025	0		27.00
28.00	SURGERY CLINIC	90.05	0	1,074	0		28.00
29.00	OPTHAMOLOGY CLINIC	90.12	0	33,236	0		29.00
30.00	ALLERGY CLINIC	90.13	0	701	0		30.00
31.00	WOUND CARE	90.14	0	24,996	0		31.00
32.00	EMERGENCY	91.00	0	95,633	0		32.00
33.00	AMBULANCE SERVICES	95.00	0	160,554	0		33.00
34.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	203,544	0		34.00
35.00	OTHER NONREIMB	194.02	0	1,188	0		35.00
36.00	RETAIL PHARMACY	194.03	0	3,025	0		36.00
	TOTALS		0	4,187,247			
	E - DRUGS RECLASS						
1.00	PHARMACY	15.00	0	2,298,923	0		1.00
	TOTALS		0	2,298,923			
	F - MED SUPPLY IMPLANTS						
1.00	INTENSIVE CARE UNIT	31.00	0	726	0		1.00
2.00	OPERATING ROOM	50.00	0	3,789,779	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	31,788	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	655,092	0		4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,103	0		5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	62,067	0		6.00
7.00	WOUND CARE	90.14	0	201,528	0		7.00
	TOTALS		0	4,754,083			
	G - CHARGABLE MED SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,062	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	12,131	0		2.00
3.00	OPERATION OF PLANT	7.00	0	36	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	1	0		4.00
5.00	HOUSEKEEPING	9.00	0	1,242	0		5.00
6.00	DIETARY	10.00	0	469	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	1	0		7.00
8.00	PHARMACY	15.00	0	22,274	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	60	0		9.00

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
10.00	ADULTS & PEDIATRICS	30.00	0	227,140	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	102,029	0	11.00
12.00	SUBPROVIDER - IPF	40.00	0	25,605	0	12.00
13.00	NURSERY	43.00	0	759	0	13.00
14.00	SKILLED NURSING FACILITY	44.00	0	40,780	0	14.00
15.00	OPERATING ROOM	50.00	0	1,907,197	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,182	0	16.00
17.00	ULTRA SOUND	55.01	0	9,149	0	17.00
18.00	CT SCAN	57.00	0	15,096	0	18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	4,400	0	19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	15,467	0	20.00
21.00	LABORATORY	60.00	0	19,235	0	21.00
22.00	PHYSICAL THERAPY	66.00	0	1,151	0	22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	143	0	23.00
24.00	AUDIOLOGY	67.01	0	11	0	24.00
25.00	SPEECH PATHOLOGY	68.00	0	1	0	25.00
26.00	CARDIOLOGY	69.01	0	13,199	0	26.00
27.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	2,536	0	27.00
28.00	UROLOGY CLINIC	90.07	0	1,315	0	28.00
29.00	ALLERGY CLINIC	90.13	0	170	0	29.00
30.00	WOUND CARE	90.14	0	25,937	0	30.00
31.00	EMERGENCY	91.00	0	358,223	0	31.00
32.00	AMBULANCE SERVICES	95.00	0	18,339	0	32.00
33.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	79,580	0	33.00
34.00	OTHER NONREIMB	194.02	0	3	0	34.00
35.00	RETAIL PHARMACY	194.03	0	92	0	35.00
	TOTALS		0	2,935,015		
	H - BONUS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,087,444	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
26.00		0.00	0	0	0	26.00
27.00		0.00	0	0	0	27.00
28.00		0.00	0	0	0	28.00
29.00		0.00	0	0	0	29.00
30.00		0.00	0	0	0	30.00
31.00		0.00	0	0	0	31.00
	TOTALS		0	1,087,444		
500.00	Grand Total: Decreases		201,548	16,100,458		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2019 2:03 pm

		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	15,743,378	76,582	0	76,582	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	84,993,937	839,521	0	839,521	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,228,155	43,486	0	43,486	0	5.00
6.00	Movable Equipment	56,679,756	4,046,329	0	4,046,329	12,996	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	159,645,226	5,005,918	0	5,005,918	12,996	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	159,645,226	5,005,918	0	5,005,918	12,996	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	15,819,960	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	85,833,458	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,271,641	0	5.00
6.00	Movable Equipment	60,713,089	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	164,638,148	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	164,638,148	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2019 2:03 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,822,999	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,822,999	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,822,999	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	3,822,999	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2019 2:03 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	85,833,458	0	85,833,458	0.974217	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,271,641	0	2,271,641	0.025783	0	2.00
3.00	Total (sum of lines 1-2)	88,105,099	0	88,105,099	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,637,404	-76,804	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	4,187,247	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,824,651	-76,804	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-420,511	156,080	0	0	3,296,169	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,187,247	2.00
3.00	Total (sum of lines 1-2)	-420,511	156,080	0	0	7,483,416	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/24/2019 2:03 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	B	-4,066	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,240,912			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service	B	-284,844	DIETARY	10.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,832	DIETARY	10.00	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	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/24/2019 2:03 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HOSP ADMIN SPONSORSHIPS/DONATIONS	A	-11,385	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	LEASE INCOME	B	-43,484	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.01
33.02	RENTAL REVENUE	B	-33,320	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.02
33.03	WELLNESS REVENUE	B	-55,035	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	EDUCATION REVENUE	B	-280	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MEDICAL STAFF FEES	B	-2,400	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	VOLUNTEER MISC REVENUE	B	-17,918	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	VOLUNTEER MEMORIALS	B	-153	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	PATIENT ACCOUNTS	B	-518	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MISC INCOME RECEIVED	B	-1,618	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	PLANT OPERATIONS	B	-925	OPERATION OF PLANT	7.00	0	33.10
33.11	MEALS ON WHEELS	B	-39,975	DIETARY	10.00	0	33.11
33.12	HEAD START & CASH (SHORT)OVER	B	-19,262	DIETARY	10.00	0	33.12
33.13	CICOA MEAL VOUCHERS	B	-7,042	DIETARY	10.00	0	33.13
33.14	PHARMACY REVENUE	B	-94	PHARMACY	15.00	0	33.14
33.15	MEDICAL RECORDS	B	-477	MEDICAL RECORDS & LIBRARY	16.00	0	33.15
33.16	RADIOLOGY DIAGNOSTIC PURCHASING DISC	B	-62	RADIOLOGY-DIAGNOSTIC	54.00	0	33.16
33.17	CENTRAL SUPPLY PURCHASING DISC	B	-51,758	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.17
33.18	AMBULANCE	B	-2,400	AMBULANCE SERVICES	95.00	0	33.18
33.19	DERMATOLOGY CLINIC RENT	A	-1,728	DERMATOLOGY CLINIC	90.03	0	33.19
33.20	SURGERY CLINIC RENT	A	-277	SURGERY CLINIC	90.05	0	33.20
33.21	UROLOGY CLINIC RENT	A	-767	UROLOGY CLINIC	90.07	0	33.21
33.22	GASTROENTEROLOGY CLINIC RENT	A	-14,658	GASTROENTEROLOGY CLINIC	90.09	0	33.22
33.23	NEUROLOGY CLINIC RENT	A	-8,480	NEUROLOGY CLINIC	90.11	0	33.23
33.24	EYE INSTITUTE RENT	A	-7,200	OPTHAMOLOGY CLINIC	90.12	0	33.24
33.25	DIALYSIS CENTER	A	-40,292	WOUND CARE	90.14	0	33.25
33.26	2010 BOND INTEREST ON INVEST	B	-1,335	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.26
33.27	2015 BOND INTEREST ON INVEST	B	-45,664	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.27
33.28	INTEREST INCOME UNNECESSARY BORROW	B	111,133	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.28
33.29	GAIN ON INVESTMENT	B	-468,667	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.29
33.30	VOLUNTEER REVENUE INTEREST	B	-153	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	GAIN/(LOSS) CIHA	A	-105,120	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	GAIN/(LOSS) SHO SPC	B	-648,949	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	GAIN/(LOSS) SHO RRG	B	-8,608	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	HEARING AID COSTS	A	-253,367	AUDIOLOGY	67.01	0	33.34
33.35	BANK FEES	A	-301,626	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	LOBBYING EXPENSE IHA DUES	A	-2,839	ADMINISTRATIVE & GENERAL	5.00	0	33.36
33.37	LOBBYING EXPENSE AHA DUES	A	-4,384	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	NONREIMBURSABLE ADVERTISING COSTS	A	-191,483	ADMINISTRATIVE & GENERAL	5.00	0	33.38
33.39	SELF INSURANCE CLAIMS PAID	B	-4,286,312	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.39
33.40	HAF FEE	A	-2,882,122	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	EMPLOYEE HEALTH REV CLIENT	B	-124,627	ADMINISTRATIVE & GENERAL	5.00	0	33.41
33.42	2017 BOND INTEREST ON INVESTMENT	B	-15,978	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.42
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,123,263				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2019 2:03 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	44.00	SKILLED NURSING FACILITY	5,800	5,800	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	380,460	380,460	0	0	0	2.00
3.00	60.00	LABORATORY	251,000	251,000	0	0	0	3.00
4.00	91.00	EMERGENCY	2,602,200	2,602,200	0	0	0	4.00
5.00	95.00	AMBULANCE SERVICES	1,452	1,452	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,240,912	3,240,912	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	44.00	SKILLED NURSING FACILITY	0	0	0	5,800	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	380,460	2.00
3.00	60.00	LABORATORY	0	0	0	251,000	3.00
4.00	91.00	EMERGENCY	0	0	0	2,602,200	4.00
5.00	95.00	AMBULANCE SERVICES	0	0	0	1,452	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	3,240,912	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/24/2019 2:03 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	3,296,169	3,296,169				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	4,187,247		4,187,247			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,991,330	7,496	9,523	10,008,349		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,769,433	239,574	304,340	1,091,005	14,404,352	5.00
7.00	00700	OPERATION OF PLANT	3,155,026	313,868	398,718	112,980	3,980,592	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	322,720	0	0	4,755	327,475	8.00
9.00	00900	HOUSEKEEPING	789,922	36,142	45,913	76,252	948,229	9.00
10.00	01000	DIETARY	1,057,776	80,901	102,772	115,098	1,356,547	10.00
11.00	01100	CAFETERIA	480,775	0	0	33,378	514,153	11.00
13.00	01300	NURSING ADMINISTRATION	902,159	0	0	137,617	1,039,776	13.00
15.00	01500	PHARMACY	7,562,050	24,975	31,727	111,916	7,730,668	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,734,266	39,452	50,118	222,300	2,046,136	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,556,802	262,411	333,351	594,559	5,747,123	30.00
31.00	03100	INTENSIVE CARE UNIT	1,574,036	72,065	91,548	192,283	1,929,932	31.00
40.00	04000	SUBPROVIDER - IPF	1,260,066	82,511	104,817	186,035	1,633,429	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	47,671	0	0	0	47,671	43.00
44.00	04400	SKILLED NURSING FACILITY	1,660,590	62,483	79,374	165,354	1,967,801	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,839,233	209,434	266,052	373,859	3,688,578	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,973,586	256,138	325,382	253,574	5,808,680	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	565,698	0	0	52,640	618,338	55.01
57.00	05700	CT SCAN	874,441	0	0	33,714	908,155	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	767,205	21,974	27,914	54,503	871,596	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,256,709	18,522	23,529	48,408	1,347,168	59.00
60.00	06000	LABORATORY	6,702,821	119,452	151,745	449,814	7,423,832	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	169,575	0	0	0	169,575	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	2,065,741	115,614	146,869	299,201	2,627,425	66.00
67.00	06700	OCCUPATIONAL THERAPY	399,934	0	0	60,644	460,578	67.00
67.01	06701	AUDIOLOGY	160,295	0	0	34,695	194,990	67.01
68.00	06800	SPEECH PATHOLOGY	200,249	0	0	29,203	229,452	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	1,263,730	11,914	15,135	180,136	1,470,915	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,865,224	0	0	0	2,865,224	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,754,083	0	0	0	4,754,083	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,236,856	0	0	0	2,236,856	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	277,471	49,229	62,537	33,075	422,312	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	1,013	1,013	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	145,883	0	0	17,448	163,331	90.13
90.14	09014	WOUND CARE	320,517	45,133	57,334	43,271	466,255	90.14
91.00	09100	EMERGENCY	2,809,780	316,418	401,958	400,322	3,928,478	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,710,242	61,310	77,885	383,889	3,233,326	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,707,311	2,447,016	3,108,541	5,792,941	87,564,044	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	8,037	10,210	0	18,247	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	34,532,590	553,111	702,633	4,160,727	39,949,061	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	18,239	23,169	0	41,408	194.01
194.02	07952	OTHER NONREIMB	174,469	264,614	336,149	11,840	787,072	194.02
194.03	07953	RETAIL PHARMACY	1,429,319	5,152	6,545	42,841	1,483,857	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/24/2019 2:03 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
202.00	TOTAL (sum lines 118 through 201)	129,843,689	3,296,169	4,187,247	10,008,349	129,843,689	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/24/2019 2:03 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,404,352					5.00
7.00	00700	OPERATION OF PLANT	496,694	4,477,286				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	40,862	0	368,337			8.00
9.00	00900	HOUSEKEEPING	118,319	68,348	0	1,134,896		9.00
10.00	01000	DIETARY	169,269	152,992	0	75,731	1,754,539	10.00
11.00	01100	CAFETERIA	64,155	0	0	25,250	0	11.00
13.00	01300	NURSING ADMINISTRATION	129,742	0	0	11,417	0	13.00
15.00	01500	PHARMACY	964,625	47,230	0	23,054	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	255,315	74,608	0	50,499	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	717,120	496,242	17,688	383,626	837,539	30.00
31.00	03100	INTENSIVE CARE UNIT	240,815	136,282	4,456	101,877	0	31.00
40.00	04000	SUBPROVIDER - IPF	203,818	156,036	3,671	121,145	352,074	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	5,948	0	1,725	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	245,540	118,160	2,704	0	564,926	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	460,257	396,058	46,927	22,615	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	724,801	484,380	31,685	102,316	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	77,156	0	8,197	6,587	0	55.01
57.00	05700	CT SCAN	113,319	0	41,739	10,100	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	108,757	41,554	14,376	9,661	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	168,098	35,027	15,441	0	0	59.00
60.00	06000	LABORATORY	926,338	225,895	54,678	43,254	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	21,159	0	862	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	3,171	0	0	64.00
66.00	06600	PHYSICAL THERAPY	327,847	218,636	7,927	15,589	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,470	0	3,196	7,465	0	67.00
67.01	06701	AUDIOLOGY	24,331	0	950	5,489	0	67.01
68.00	06800	SPEECH PATHOLOGY	28,631	0	1,016	3,293	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	183,539	22,531	13,187	33,154	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	357,520	0	8,268	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	593,210	0	13,107	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	279,113	0	34,927	23,932	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	52,696	93,096	0	58,842	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	142	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	126	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	20,380	0	671	0	0	90.13
90.14	09014	WOUND CARE	58,179	85,350	3,721	0	0	90.14
91.00	09100	EMERGENCY	490,192	598,374	30,056	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	403,451	42,870	3,849	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,128,792	3,493,669	368,337	1,134,896	1,754,539	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,277	15,199	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,984,752	924,184	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	5,167	34,491	0	0	0	194.01
194.02	07952	OTHER NONREIMB	98,210	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	185,154	9,743	0	0	0	194.03
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)	14,404,352	4,477,286	368,337	1,134,896	1,754,539	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/24/2019 2:03 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	603,558					11.00
13.00	01300	NURSING ADMINISTRATION	11,678	1,192,613				13.00
15.00	01500	PHARMACY	23,356	0	8,788,933			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	47,326	0	0	2,473,884		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	159,188	270,074	12,839	607,936	9,249,375	30.00
31.00	03100	INTENSIVE CARE UNIT	12,907	80,005	578	126,403	2,633,255	31.00
40.00	04000	SUBPROVIDER - IPF	20,282	100,468	269	150,480	2,741,672	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	55,344	43.00
44.00	04400	SKILLED NURSING FACILITY	0	98,089	7,307	0	3,004,527	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,136	180,410	41,765	218,195	5,068,941	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,209	0	3,006	583,861	7,755,938	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	1,844	0	3,604	63,201	778,927	55.01
57.00	05700	CT SCAN	2,458	0	1,130	72,230	1,149,131	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,146	0	11,537	39,125	1,102,752	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	19,159	0	0	1,584,893	59.00
60.00	06000	LABORATORY	50,399	0	347	60,192	8,784,935	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	191,596	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	3,171	64.00
66.00	06600	PHYSICAL THERAPY	25,199	85,492	7,482	117,374	3,432,971	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,449	26,157	0	51,163	616,478	67.00
67.01	06701	AUDIOLOGY	11,063	18,574	0	0	255,397	67.01
68.00	06800	SPEECH PATHOLOGY	11,678	12,431	0	0	286,501	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	25,199	83,924	56	112,860	1,945,365	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,907	0	0	0	3,243,919	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	5,360,400	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,574,828	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	20,897	16,863	8	252,806	917,520	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	702	0	702	90.05
90.07	09007	UROLOGY CLINIC	0	0	841	0	983	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	12,680	0	0	13,819	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	7,878	5,170	0	197,430	90.13
90.14	09014	WOUND CARE	0	21,845	23,902	0	659,252	90.14
91.00	09100	EMERGENCY	39,336	149,482	210,268	0	5,446,186	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	79,901	0	89,865	0	3,853,262	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	603,558	1,183,531	420,676	2,455,826	72,909,470	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	35,723	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,102	5,861,495	18,058	51,740,652	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	81,066	194.01
194.02	07952	OTHER NONREIMB	0	5,980	0	0	891,262	194.02
194.03	07953	RETAIL PHARMACY	0	0	2,506,762	0	4,185,516	194.03
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)	603,558	1,192,613	8,788,933	2,473,884	129,843,689	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/24/2019 2:03 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	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
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	9,249,375	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,633,255	31.00
40.00	04000	SUBPROVIDER - IPF	0	2,741,672	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	55,344	43.00
44.00	04400	SKILLED NURSING FACILITY	0	3,004,527	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	5,068,941	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,755,938	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501	ULTRA SOUND	0	778,927	55.01
57.00	05700	CT SCAN	0	1,149,131	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,102,752	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,584,893	59.00
60.00	06000	LABORATORY	0	8,784,935	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	191,596	63.00
64.00	06400	INTRAVENOUS THERAPY	0	3,171	64.00
66.00	06600	PHYSICAL THERAPY	0	3,432,971	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	616,478	67.00
67.01	06701	AUDIOLOGY	0	255,397	67.01
68.00	06800	SPEECH PATHOLOGY	0	286,501	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIOLOGY	0	1,945,365	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,243,919	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,360,400	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,574,828	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	917,520	90.01
90.02	09002	CLINIC	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	90.03
90.04	09004	ENT CLINIC	0	0	90.04
90.05	09005	SURGERY CLINIC	0	702	90.05
90.07	09007	UROLOGY CLINIC	0	983	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	13,819	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	197,430	90.13
90.14	09014	WOUND CARE	0	659,252	90.14
91.00	09100	EMERGENCY	0	5,446,186	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	3,853,262	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	72,909,470	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	35,723	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	51,740,652	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	81,066	194.01
194.02	07952	OTHER NONREIMB	0	891,262	194.02
194.03	07953	RETAIL PHARMACY	0	4,185,516	194.03
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	129,843,689	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/24/2019 2:03 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,496	9,523	17,019	17,019	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	239,574	304,340	543,914	1,858	5.00
7.00	00700	OPERATION OF PLANT	0	313,868	398,718	712,586	192	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8	8.00
9.00	00900	HOUSEKEEPING	0	36,142	45,913	82,055	130	9.00
10.00	01000	DIETARY	0	80,901	102,772	183,673	196	10.00
11.00	01100	CAFETERIA	0	0	0	0	57	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	234	13.00
15.00	01500	PHARMACY	0	24,975	31,727	56,702	191	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	39,452	50,118	89,570	379	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	262,411	333,351	595,762	1,012	30.00
31.00	03100	INTENSIVE CARE UNIT	0	72,065	91,548	163,613	327	31.00
40.00	04000	SUBPROVIDER - IPF	0	82,511	104,817	187,328	317	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	62,483	79,374	141,857	282	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	209,434	266,052	475,486	637	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	256,138	325,382	581,520	432	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	90	55.01
57.00	05700	CT SCAN	0	0	0	0	57	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	21,974	27,914	49,888	93	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	18,522	23,529	42,051	82	59.00
60.00	06000	LABORATORY	0	119,452	151,745	271,197	766	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	115,614	146,869	262,483	509	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	103	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	59	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	50	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	11,914	15,135	27,049	307	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	49,229	62,537	111,766	56	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	2	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	30	90.13
90.14	09014	WOUND CARE	0	45,133	57,334	102,467	74	90.14
91.00	09100	EMERGENCY	0	316,418	401,958	718,376	682	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	61,310	77,885	139,195	654	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,447,016	3,108,541	5,555,557	9,866	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	8,037	10,210	18,247	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	553,111	702,633	1,255,744	7,060	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	18,239	23,169	41,408	0	194.01
194.02	07952	OTHER NONREIMB	0	264,614	336,149	600,763	20	194.02
194.03	07953	RETAIL PHARMACY	0	5,152	6,545	11,697	73	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,296,169	4,187,247	7,483,416	17,019	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/24/2019 2:03 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	545,772					5.00
7.00	00700	OPERATION OF PLANT	18,820	731,598				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,548	0	1,556			8.00
9.00	00900	HOUSEKEEPING	4,483	11,168	0	97,836		9.00
10.00	01000	DIETARY	6,414	24,999	0	6,529	221,811	10.00
11.00	01100	CAFETERIA	2,431	0	0	2,177	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,916	0	0	984	0	13.00
15.00	01500	PHARMACY	36,551	7,717	0	1,987	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,674	12,191	0	4,353	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,172	81,087	73	33,070	105,882	30.00
31.00	03100	INTENSIVE CARE UNIT	9,125	22,269	18	8,782	0	31.00
40.00	04000	SUBPROVIDER - IPF	7,723	25,497	15	10,444	44,510	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	225	0	7	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	9,304	19,308	11	0	71,419	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,440	64,717	193	1,950	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,463	79,149	131	8,820	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	2,924	0	34	568	0	55.01
57.00	05700	CT SCAN	4,294	0	172	871	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,121	6,790	59	833	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,369	5,723	64	0	0	59.00
60.00	06000	LABORATORY	35,100	36,912	263	3,729	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	802	0	4	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	13	0	0	64.00
66.00	06600	PHYSICAL THERAPY	12,422	35,726	33	1,344	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,178	0	13	644	0	67.00
67.01	06701	AUDIOLOGY	922	0	4	473	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,085	0	4	284	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	6,954	3,682	54	2,858	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,547	0	34	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	22,477	0	54	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,576	0	144	2,063	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	1,997	15,212	0	5,073	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	1	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	5	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	772	0	3	0	0	90.13
90.14	09014	WOUND CARE	2,204	13,946	15	0	0	90.14
91.00	09100	EMERGENCY	18,574	97,776	124	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	15,287	7,005	16	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	345,899	570,874	1,556	97,836	221,811	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	86	2,484	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	188,854	151,012	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	196	5,636	0	0	0	194.01
194.02	07952	OTHER NONREIMB	3,721	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	7,016	1,592	0	0	0	194.03
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)	545,772	731,598	1,556	97,836	221,811	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/24/2019 2:03 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	4,665					11.00
13.00	01300	NURSING ADMINISTRATION	90	6,224				13.00
15.00	01500	PHARMACY	181	0	103,329			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	366	0	0	116,533		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,227	1,410	151	28,639	875,485	30.00
31.00	03100	INTENSIVE CARE UNIT	100	418	7	5,954	210,613	31.00
40.00	04000	SUBPROVIDER - IPF	157	524	3	7,088	283,606	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	232	43.00
44.00	04400	SKILLED NURSING FACILITY	0	512	86	0	242,779	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	109	941	491	10,278	572,242	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	133	0	35	27,503	725,186	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	14	0	42	2,977	6,649	55.01
57.00	05700	CT SCAN	19	0	13	3,402	8,828	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	48	0	136	1,843	63,811	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	100	0	0	54,389	59.00
60.00	06000	LABORATORY	390	0	4	2,835	351,196	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	806	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	13	64.00
66.00	06600	PHYSICAL THERAPY	195	446	88	5,529	318,775	66.00
67.00	06700	OCCUPATIONAL THERAPY	81	137	0	2,410	5,566	67.00
67.01	06701	AUDIOLOGY	86	97	0	0	1,641	67.01
68.00	06800	SPEECH PATHOLOGY	90	65	0	0	1,578	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	195	438	1	5,316	46,854	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	100	0	0	0	13,681	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	22,531	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	12,783	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	162	88	0	11,908	146,262	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	8	0	8	90.05
90.07	09007	UROLOGY CLINIC	0	0	10	0	11	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	66	0	0	73	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	41	61	0	907	90.13
90.14	09014	WOUND CARE	0	114	281	0	119,101	90.14
91.00	09100	EMERGENCY	304	780	2,472	0	839,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	618	0	1,057	0	163,832	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,665	6,177	4,946	115,682	5,088,526	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	20,817	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	16	68,912	851	1,672,449	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	47,240	194.01
194.02	07952	OTHER NONREIMB	0	31	0	0	604,535	194.02
194.03	07953	RETAIL PHARMACY	0	0	29,471	0	49,849	194.03
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)	4,665	6,224	103,329	116,533	7,483,416	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/24/2019 2:03 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	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
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	875,485	30.00
31.00	03100	INTENSIVE CARE UNIT	0	210,613	31.00
40.00	04000	SUBPROVIDER - IPF	0	283,606	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	232	43.00
44.00	04400	SKILLED NURSING FACILITY	0	242,779	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	572,242	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	725,186	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501	ULTRA SOUND	0	6,649	55.01
57.00	05700	CT SCAN	0	8,828	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	63,811	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	54,389	59.00
60.00	06000	LABORATORY	0	351,196	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	806	63.00
64.00	06400	INTRAVENOUS THERAPY	0	13	64.00
66.00	06600	PHYSICAL THERAPY	0	318,775	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,566	67.00
67.01	06701	AUDIOLOGY	0	1,641	67.01
68.00	06800	SPEECH PATHOLOGY	0	1,578	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIOLOGY	0	46,854	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,681	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	22,531	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,783	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	146,262	90.01
90.02	09002	CLINIC	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	90.03
90.04	09004	ENT CLINIC	0	0	90.04
90.05	09005	SURGERY CLINIC	0	8	90.05
90.07	09007	UROLOGY CLINIC	0	11	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	73	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	907	90.13
90.14	09014	WOUND CARE	0	119,101	90.14
91.00	09100	EMERGENCY	0	839,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	163,832	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,088,526	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	20,817	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,672,449	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	47,240	194.01
194.02	07952	OTHER NONREIMB	0	604,535	194.02
194.03	07953	RETAIL PHARMACY	0	49,849	194.03
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,483,416	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 2:03 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	255,907					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		255,907				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	582	582	60,433,151			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,600	18,600	6,587,798	-14,404,352	115,439,337	5.00
7.00	00700	OPERATION OF PLANT	24,368	24,368	682,203	0	3,980,592	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	28,715	0	327,475	8.00
9.00	00900	HOUSEKEEPING	2,806	2,806	460,434	0	948,229	9.00
10.00	01000	DIETARY	6,281	6,281	694,992	0	1,356,547	10.00
11.00	01100	CAFETERIA	0	0	201,548	0	514,153	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	830,969	0	1,039,776	13.00
15.00	01500	PHARMACY	1,939	1,939	675,778	0	7,730,668	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	3,063	1,342,309	0	2,046,136	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,373	20,373	3,590,113	0	5,747,123	30.00
31.00	03100	INTENSIVE CARE UNIT	5,595	5,595	1,161,060	0	1,929,932	31.00
40.00	04000	SUBPROVIDER - IPF	6,406	6,406	1,123,334	0	1,633,429	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	47,671	43.00
44.00	04400	SKILLED NURSING FACILITY	4,851	4,851	998,457	0	1,967,801	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,260	16,260	2,257,466	0	3,688,578	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,886	19,886	1,531,151	0	5,808,680	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	317,858	0	618,338	55.01
57.00	05700	CT SCAN	0	0	203,573	0	908,155	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	1,706	329,105	0	871,596	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,438	1,438	292,304	0	1,347,168	59.00
60.00	06000	LABORATORY	9,274	9,274	2,716,106	0	7,423,832	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	169,575	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,976	8,976	1,806,658	0	2,627,425	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	366,187	0	460,578	67.00
67.01	06701	AUDIOLOGY	0	0	209,497	0	194,990	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	176,334	0	229,452	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	925	925	1,087,713	0	1,470,915	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,865,224	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,754,083	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,236,856	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	3,822	3,822	199,717	0	422,312	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	6,115	0	1,013	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	105,358	0	163,331	90.13
90.14	09014	WOUND CARE	3,504	3,504	261,280	0	466,255	90.14
91.00	09100	EMERGENCY	24,566	24,566	2,417,258	0	3,928,478	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,760	4,760	2,318,031	0	3,233,326	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	189,981	189,981	34,979,421	-14,404,352	73,159,692	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	624	0	0	18,247	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	42,942	42,942	25,123,550	0	39,949,061	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	1,416	1,416	0	0	41,408	194.01
194.02	07952	OTHER NONREIMB	20,544	20,544	71,491	0	787,072	194.02
194.03	07953	RETAIL PHARMACY	400	400	258,689	0	1,483,857	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 2:03 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	3,296,169	4,187,247	10,008,349		14,404,352	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.880339	16.362378	0.165610		0.124779	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			17,019		545,772	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000282		0.004728	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: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 2:03 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	183,813					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	379,193,901				8.00
9.00	00900	HOUSEKEEPING	2,806	0	129,223			9.00
10.00	01000	DIETARY	6,281	0	8,623	48,444		10.00
11.00	01100	CAFETERIA	0	0	2,875	0	982	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,300	0	19	13.00
15.00	01500	PHARMACY	1,939	0	2,625	0	38	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	0	5,750	0	77	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,373	18,215,821	43,681	23,125	259	30.00
31.00	03100	INTENSIVE CARE UNIT	5,595	4,588,887	11,600	0	21	31.00
40.00	04000	SUBPROVIDER - IPF	6,406	3,780,153	13,794	9,721	33	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	1,776,485	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,851	2,784,782	0	15,598	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,260	48,328,351	2,575	0	23	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,886	32,631,664	11,650	0	28	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	8,442,283	750	0	3	55.01
57.00	05700	CT SCAN	0	42,985,910	1,150	0	4	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	14,805,232	1,100	0	10	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,438	15,902,581	0	0	0	59.00
60.00	06000	LABORATORY	9,274	56,165,181	4,925	0	82	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	888,126	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	3,265,907	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,976	8,164,154	1,775	0	41	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,291,358	850	0	17	67.00
67.01	06701	AUDIOLOGY	0	978,602	625	0	18	67.01
68.00	06800	SPEECH PATHOLOGY	0	1,046,819	375	0	19	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	925	13,580,789	3,775	0	41	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,515,031	0	0	21	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	13,498,637	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	35,970,008	2,725	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	3,822	0	6,700	0	34	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	146,056	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	691,366	0	0	0	90.13
90.14	09014	WOUND CARE	3,504	3,832,589	0	0	0	90.14
91.00	09100	EMERGENCY	24,566	30,953,463	0	0	64	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,760	3,963,666	0	0	130	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	143,431	379,193,901	129,223	48,444	982	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	37,942	0	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	1,416	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	400	0	0	0	0	194.03
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)	4,477,286	368,337	1,134,896	1,754,539	603,558	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.357831	0.000971	8.782461	36.217880	614.621181	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 2:03 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	731,598	1,556	97,836	221,811	4,665	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.980121	0.000004	0.757110	4.578709	4.750509	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: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 2:03 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	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	416,004				13.00
15.00	01500	PHARMACY	0	3,467,831			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	41,100		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	94,207	5,066	10,100		30.00
31.00	03100	INTENSIVE CARE UNIT	27,907	228	2,100		31.00
40.00	04000	SUBPROVIDER - IPF	35,045	106	2,500		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	34,215	2,883	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	62,930	16,479	3,625		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,186	9,700		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	05501	ULTRA SOUND	0	1,422	1,050		55.01
57.00	05700	CT SCAN	0	446	1,200		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,552	650		58.00
59.00	05900	CARDIAC CATHETERIZATION	6,683	0	0		59.00
60.00	06000	LABORATORY	0	137	1,000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	29,821	2,952	1,950		66.00
67.00	06700	OCCUPATIONAL THERAPY	9,124	0	850		67.00
67.01	06701	AUDIOLOGY	6,479	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	4,336	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIOLOGY	29,274	22	1,875		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	5,882	3	4,200		90.01
90.02	09002	CLINIC	0	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0		90.03
90.04	09004	ENT CLINIC	0	0	0		90.04
90.05	09005	SURGERY CLINIC	0	277	0		90.05
90.07	09007	UROLOGY CLINIC	0	332	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	4,423	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0		90.12
90.13	09013	ALLERGY CLINIC	2,748	2,040	0		90.13
90.14	09014	WOUND CARE	7,620	9,431	0		90.14
91.00	09100	EMERGENCY	52,142	82,965	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	35,458	0		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	412,836	165,985	40,800		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,082	2,312,758	300		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0		194.01
194.02	07952	OTHER NONREIMB	2,086	0	0		194.02
194.03	07953	RETAIL PHARMACY	0	989,088	0		194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,192,613	8,788,933	2,473,884		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/24/2019 2:03 pm

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	15.00	16.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	2.866831	2.534418	60.191825	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	6,224	103,329	116,533	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.014961	0.029796	2.835353	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/24/2019 2:03 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,249,375		9,249,375	0	9,249,375	30.00
31.00	03100	INTENSIVE CARE UNIT	2,633,255		2,633,255	0	2,633,255	31.00
40.00	04000	SUBPROVIDER - IPF	2,741,672		2,741,672	0	2,741,672	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	55,344		55,344	0	55,344	43.00
44.00	04400	SKILLED NURSING FACILITY	3,004,527		3,004,527	0	3,004,527	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,068,941		5,068,941	0	5,068,941	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,755,938		7,755,938	0	7,755,938	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
55.01	05501	ULTRA SOUND	778,927		778,927	0	778,927	55.01
57.00	05700	CT SCAN	1,149,131		1,149,131	0	1,149,131	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,102,752		1,102,752	0	1,102,752	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,584,893		1,584,893	0	1,584,893	59.00
60.00	06000	LABORATORY	8,784,935		8,784,935	0	8,784,935	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	191,596		191,596	0	191,596	63.00
64.00	06400	INTRAVENOUS THERAPY	3,171		3,171	0	3,171	64.00
66.00	06600	PHYSICAL THERAPY	3,432,971	0	3,432,971	0	3,432,971	66.00
67.00	06700	OCCUPATIONAL THERAPY	616,478	0	616,478	0	616,478	67.00
67.01	06701	AUDIOLOGY	255,397	0	255,397	0	255,397	67.01
68.00	06800	SPEECH PATHOLOGY	286,501	0	286,501	0	286,501	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIOLOGY	1,945,365		1,945,365	0	1,945,365	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,243,919		3,243,919	0	3,243,919	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,360,400		5,360,400	0	5,360,400	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,574,828		2,574,828	0	2,574,828	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	917,520		917,520	0	917,520	90.01
90.02	09002	CLINIC	0		0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	90.03
90.04	09004	ENT CLINIC	0		0	0	0	90.04
90.05	09005	SURGERY CLINIC	702		702	0	702	90.05
90.07	09007	UROLOGY CLINIC	983		983	0	983	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	13,819		13,819	0	13,819	90.09
90.11	09011	NEUROLOGY CLINIC	0		0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0		0	0	0	90.12
90.13	09013	ALLERGY CLINIC	197,430		197,430	0	197,430	90.13
90.14	09014	WOUND CARE	659,252		659,252	0	659,252	90.14
91.00	09100	EMERGENCY	5,446,186		5,446,186	0	5,446,186	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,039,298		2,039,298		2,039,298	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,853,262		3,853,262	0	3,853,262	95.00
200.00		Subtotal (see instructions)	74,948,768	0	74,948,768	0	74,948,768	200.00
201.00		Less Observation Beds	2,039,298		2,039,298		2,039,298	201.00
202.00		Total (see instructions)	72,909,470	0	72,909,470	0	72,909,470	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/24/2019 2:03 pm

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	14,261,173		14,261,173			30.00
31.00	03100	INTENSIVE CARE UNIT	4,588,887		4,588,887			31.00
40.00	04000	SUBPROVIDER - IPF	3,780,153		3,780,153			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,776,485		1,776,485			43.00
44.00	04400	SKILLED NURSING FACILITY	2,784,782		2,784,782			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,493,324	39,835,027	48,328,351	0.104885	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,521,417	31,110,247	32,631,664	0.237681	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	05501	ULTRA SOUND	464,785	7,977,498	8,442,283	0.092265	0.000000	55.01
57.00	05700	CT SCAN	4,731,190	38,254,720	42,985,910	0.026733	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	698,553	14,106,679	14,805,232	0.074484	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,591,946	11,310,635	15,902,581	0.099663	0.000000	59.00
60.00	06000	LABORATORY	9,279,040	46,886,141	56,165,181	0.156412	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	509,804	378,322	888,126	0.215731	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	1,456,622	1,809,285	3,265,907	0.000971	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	2,622,018	5,542,136	8,164,154	0.420493	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,505,651	785,707	3,291,358	0.187302	0.000000	67.00
67.01	06701	AUDIOLOGY	0	978,602	978,602	0.260981	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	253,569	793,250	1,046,819	0.273687	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	06901	CARDIOLOGY	5,330,292	8,250,497	13,580,789	0.143244	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,669,181	4,845,850	8,515,031	0.380964	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,378,133	10,120,504	13,498,637	0.397107	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,942,305	27,027,703	35,970,008	0.071583	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0.000000	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0.000000	0.000000	90.05
90.07	09007	UROLOGY CLINIC	1,240	144,816	146,056	0.006730	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0.000000	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0.000000	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0.000000	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	691,366	691,366	0.285565	0.000000	90.13
90.14	09014	WOUND CARE	14,983	3,817,606	3,832,589	0.172012	0.000000	90.14
91.00	09100	EMERGENCY	4,070,948	26,882,515	30,953,463	0.175948	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,954,648	3,954,648	0.515671	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,515	3,959,151	3,963,666	0.972146	0.000000	95.00
200.00		Subtotal (see instructions)	89,730,996	289,462,905	379,193,901			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	89,730,996	289,462,905	379,193,901			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.104885	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237681	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
55.01	05501	ULTRA SOUND	0.092265	55.01
57.00	05700	CT SCAN	0.026733	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.074484	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099663	59.00
60.00	06000	LABORATORY	0.156412	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.215731	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000971	64.00
66.00	06600	PHYSICAL THERAPY	0.420493	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.187302	67.00
67.01	06701	AUDIOLOGY	0.260981	67.01
68.00	06800	SPEECH PATHOLOGY	0.273687	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	CARDIOLOGY	0.143244	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.380964	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.397107	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071583	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	90.01
90.02	09002	CLINIC	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	90.03
90.04	09004	ENT CLINIC	0.000000	90.04
90.05	09005	SURGERY CLINIC	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0.006730	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0.285565	90.13
90.14	09014	WOUND CARE	0.172012	90.14
91.00	09100	EMERGENCY	0.175948	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.515671	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.972146	95.00
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: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/24/2019 2:03 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,249,375		9,249,375	0	9,249,375	30.00
31.00	03100	INTENSIVE CARE UNIT	2,633,255		2,633,255	0	2,633,255	31.00
40.00	04000	SUBPROVIDER - IPF	2,741,672		2,741,672	0	2,741,672	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	55,344		55,344	0	55,344	43.00
44.00	04400	SKILLED NURSING FACILITY	3,004,527		3,004,527	0	3,004,527	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,068,941		5,068,941	0	5,068,941	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,755,938		7,755,938	0	7,755,938	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
55.01	05501	ULTRA SOUND	778,927		778,927	0	778,927	55.01
57.00	05700	CT SCAN	1,149,131		1,149,131	0	1,149,131	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,102,752		1,102,752	0	1,102,752	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,584,893		1,584,893	0	1,584,893	59.00
60.00	06000	LABORATORY	8,784,935		8,784,935	0	8,784,935	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	191,596		191,596	0	191,596	63.00
64.00	06400	INTRAVENOUS THERAPY	3,171		3,171	0	3,171	64.00
66.00	06600	PHYSICAL THERAPY	3,432,971	0	3,432,971	0	3,432,971	66.00
67.00	06700	OCCUPATIONAL THERAPY	616,478	0	616,478	0	616,478	67.00
67.01	06701	AUDIOLOGY	255,397	0	255,397	0	255,397	67.01
68.00	06800	SPEECH PATHOLOGY	286,501	0	286,501	0	286,501	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIOLOGY	1,945,365		1,945,365	0	1,945,365	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,243,919		3,243,919	0	3,243,919	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,360,400		5,360,400	0	5,360,400	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,574,828		2,574,828	0	2,574,828	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	917,520		917,520	0	917,520	90.01
90.02	09002	CLINIC	0		0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	90.03
90.04	09004	ENT CLINIC	0		0	0	0	90.04
90.05	09005	SURGERY CLINIC	702		702	0	702	90.05
90.07	09007	UROLOGY CLINIC	983		983	0	983	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	13,819		13,819	0	13,819	90.09
90.11	09011	NEUROLOGY CLINIC	0		0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0		0	0	0	90.12
90.13	09013	ALLERGY CLINIC	197,430		197,430	0	197,430	90.13
90.14	09014	WOUND CARE	659,252		659,252	0	659,252	90.14
91.00	09100	EMERGENCY	5,446,186		5,446,186	0	5,446,186	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,039,298		2,039,298		2,039,298	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,853,262		3,853,262	0	3,853,262	95.00
200.00		Subtotal (see instructions)	74,948,768	0	74,948,768	0	74,948,768	200.00
201.00		Less Observation Beds	2,039,298		2,039,298		2,039,298	201.00
202.00		Total (see instructions)	72,909,470	0	72,909,470	0	72,909,470	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/24/2019 2:03 pm

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	14,261,173		14,261,173			30.00
31.00	03100	INTENSIVE CARE UNIT	4,588,887		4,588,887			31.00
40.00	04000	SUBPROVIDER - IPF	3,780,153		3,780,153			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,776,485		1,776,485			43.00
44.00	04400	SKILLED NURSING FACILITY	2,784,782		2,784,782			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,493,324	39,835,027	48,328,351	0.104885	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,521,417	31,110,247	32,631,664	0.237681	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	05501	ULTRA SOUND	464,785	7,977,498	8,442,283	0.092265	0.000000	55.01
57.00	05700	CT SCAN	4,731,190	38,254,720	42,985,910	0.026733	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	698,553	14,106,679	14,805,232	0.074484	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,591,946	11,310,635	15,902,581	0.099663	0.000000	59.00
60.00	06000	LABORATORY	9,279,040	46,886,141	56,165,181	0.156412	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	509,804	378,322	888,126	0.215731	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	1,456,622	1,809,285	3,265,907	0.000971	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	2,622,018	5,542,136	8,164,154	0.420493	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,505,651	785,707	3,291,358	0.187302	0.000000	67.00
67.01	06701	AUDIOLOGY	0	978,602	978,602	0.260981	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	253,569	793,250	1,046,819	0.273687	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	06901	CARDIOLOGY	5,330,292	8,250,497	13,580,789	0.143244	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,669,181	4,845,850	8,515,031	0.380964	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,378,133	10,120,504	13,498,637	0.397107	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,942,305	27,027,703	35,970,008	0.071583	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0.000000	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0.000000	0.000000	90.05
90.07	09007	UROLOGY CLINIC	1,240	144,816	146,056	0.006730	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0.000000	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0.000000	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0.000000	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	691,366	691,366	0.285565	0.000000	90.13
90.14	09014	WOUND CARE	14,983	3,817,606	3,832,589	0.172012	0.000000	90.14
91.00	09100	EMERGENCY	4,070,948	26,882,515	30,953,463	0.175948	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,954,648	3,954,648	0.515671	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,515	3,959,151	3,963,666	0.972146	0.000000	95.00
200.00		Subtotal (see instructions)	89,730,996	289,462,905	379,193,901			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	89,730,996	289,462,905	379,193,901			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/24/2019 2:03 pm

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
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
55.01	05501	ULTRA SOUND	0.000000	55.01
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
67.01	06701	AUDIOLOGY	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	CARDIOLOGY	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	90.01
90.02	09002	CLINIC	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	90.03
90.04	09004	ENT CLINIC	0.000000	90.04
90.05	09005	SURGERY CLINIC	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0.000000	90.13
90.14	09014	WOUND CARE	0.000000	90.14
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
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: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I | Date/Time Prepared: 5/24/2019 2:03 pm

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	875,485	0	875,485	7,012	124.86	30.00
31.00	INTENSIVE CARE UNIT	210,613		210,613	1,776	118.59	31.00
40.00	SUBPROVIDER - IPF	283,606	0	283,606	3,133	90.52	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	232		232	1,060	0.22	43.00
44.00	SKILLED NURSING FACILITY	242,779		242,779	5,027	48.30	44.00
200.00	Total (lines 30 through 199)	1,612,715		1,612,715	18,008		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,263	282,558	30.00
31.00	INTENSIVE CARE UNIT	834	98,904	31.00
40.00	SUBPROVIDER - IPF	2,558	231,550	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	2,994	144,610	44.00
200.00	Total (lines 30 through 199)	8,649	757,622	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II | Date/Time Prepared: 5/24/2019 2:03 pm

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	572,242	48,328,351	0.011841	5,047,393	59,766	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	725,186	32,631,664	0.022223	1,014,030	22,535	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	6,649	8,442,283	0.000788	61,493	48	55.01
57.00	05700	CT SCAN	8,828	42,985,910	0.000205	2,179,917	447	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	63,811	14,805,232	0.004310	369,800	1,594	58.00
59.00	05900	CARDIAC CATHETERIZATION	54,389	15,902,581	0.003420	630,920	2,158	59.00
60.00	06000	LABORATORY	351,196	56,165,181	0.006253	4,371,941	27,338	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	806	888,126	0.000908	161,160	146	63.00
64.00	06400	INTRAVENOUS THERAPY	13	3,265,907	0.000004	618,537	2	64.00
66.00	06600	PHYSICAL THERAPY	318,775	8,164,154	0.039046	413,946	16,163	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,566	3,291,358	0.001691	289,225	489	67.00
67.01	06701	AUDIOLOGY	1,641	978,602	0.001677	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,578	1,046,819	0.001507	78,073	118	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	46,854	13,580,789	0.003450	3,910,273	13,490	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,681	8,515,031	0.001607	1,410,565	2,267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	22,531	13,498,637	0.001669	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,783	35,970,008	0.000355	3,412,199	1,211	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	146,262	0	0.000000	0	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	8	0	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	11	146,056	0.000075	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	73	0	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	907	691,366	0.001312	0	0	90.13
90.14	09014	WOUND CARE	119,101	3,832,589	0.031076	582	18	90.14
91.00	09100	EMERGENCY	839,088	30,953,463	0.027108	1,838,782	49,846	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	193,026	3,954,648	0.048810	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,505,005	348,038,755		25,808,836	197,636	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/24/2019 2:03 pm

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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	7,012	0.00	2,263	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,776	0.00	834	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	3,133	0.00	2,558	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00
43.00	04300	NURSERY		0	1,060	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	5,027	0.00	2,994	44.00
200.00		Total (lines 30 through 199)		0	18,008		8,649	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
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/24/2019 2:03 pm

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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
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	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/24/2019 2:03 pm

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	48,328,351	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,631,664	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
55.01	05501	ULTRA SOUND	0	0	0	8,442,283	0.000000	55.01
57.00	05700	CT SCAN	0	0	0	42,985,910	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	14,805,232	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	15,902,581	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	56,165,181	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	888,126	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,265,907	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,164,154	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,291,358	0.000000	67.00
67.01	06701	AUDIOLOGY	0	0	0	978,602	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,046,819	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	06901	CARDIOLOGY	0	0	0	13,580,789	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,515,031	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	13,498,637	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	35,970,008	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	146,056	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	691,366	0.000000	90.13
90.14	09014	WOUND CARE	0	0	0	3,832,589	0.000000	90.14
91.00	09100	EMERGENCY	0	0	0	30,953,463	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,954,648	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	348,038,755		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104

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

Worksheet D Part IV

Date/Time Prepared: 5/24/2019 2:03 pm

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	5,047,393	0	13,509,124	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,014,030	0	8,504,410	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.000000	61,493	0	892,550	0	55.01
57.00	05700	CT SCAN	0.000000	2,179,917	0	9,739,025	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	369,800	0	4,719,246	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	630,920	0	1,378,672	0	59.00
60.00	06000	LABORATORY	0.000000	4,371,941	0	5,200,929	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	161,160	0	104,819	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	618,537	0	438,898	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	413,946	0	15,494	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	289,225	0	9,357	0	67.00
67.01	06701	AUDIOLOGY	0.000000	0	0	128,533	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	78,073	0	806	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.000000	3,910,273	0	5,866,087	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,410,565	0	1,255,833	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	24,969	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,412,199	0	8,444,476	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.000000	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.000000	582	0	684,252	0	90.14
91.00	09100	EMERGENCY	0.000000	1,838,782	0	4,890,665	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	2,056,475	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		25,808,836	0	67,864,620	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.104885	13,509,124	0	0	1,416,904	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237681	8,504,410	0	1	2,021,337	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.092265	892,550	0	0	82,351	55.01
57.00	05700	CT SCAN	0.026733	9,739,025	0	7,058	260,353	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.074484	4,719,246	0	0	351,508	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099663	1,378,672	0	0	137,403	59.00
60.00	06000	LABORATORY	0.156412	5,200,929	0	0	813,488	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.215731	104,819	0	0	22,613	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000971	438,898	0	0	426	64.00
66.00	06600	PHYSICAL THERAPY	0.420493	15,494	0	0	6,515	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.187302	9,357	0	0	1,753	67.00
67.01	06701	AUDIOLOGY	0.260981	128,533	0	0	33,545	67.01
68.00	06800	SPEECH PATHOLOGY	0.273687	806	0	0	221	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.143244	5,866,087	0	0	840,282	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.380964	1,255,833	0	0	478,427	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.397107	24,969	0	0	9,915	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071583	8,444,476	0	33,174	604,481	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.006730	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.285565	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.172012	684,252	0	1,287	117,700	90.14
91.00	09100	EMERGENCY	0.175948	4,890,665	0	110	860,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.515671	2,056,475	0	22	1,060,465	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.972146		0			95.00
200.00		Subtotal (see instructions)		67,864,620	0	41,652	9,120,190	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		67,864,620	0	41,652	9,120,190	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/24/2019 2:03 pm

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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	55.01
57.00	05700	CT SCAN	0	189	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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,375	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	90.01
90.02	09002	CLINIC	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	90.03
90.04	09004	ENT CLINIC	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	90.13
90.14	09014	WOUND CARE	0	221	90.14
91.00	09100	EMERGENCY	0	19	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	11	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	2,815	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	2,815	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Subprovider - IPF | 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	572,242	48,328,351	0.011841	12,019	142	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	725,186	32,631,664	0.022223	48,473	1,077	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	6,649	8,442,283	0.000788	0	0	55.01
57.00	05700	CT SCAN	8,828	42,985,910	0.000205	47,651	10	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	63,811	14,805,232	0.004310	6,110	26	58.00
59.00	05900	CARDIAC CATHETERIZATION	54,389	15,902,581	0.003420	8,065	28	59.00
60.00	06000	LABORATORY	351,196	56,165,181	0.006253	564,324	3,529	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	806	888,126	0.000908	1,736	2	63.00
64.00	06400	INTRAVENOUS THERAPY	13	3,265,907	0.000004	5,300	0	64.00
66.00	06600	PHYSICAL THERAPY	318,775	8,164,154	0.039046	33,913	1,324	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,566	3,291,358	0.001691	19,941	34	67.00
67.01	06701	AUDIOLOGY	1,641	978,602	0.001677	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,578	1,046,819	0.001507	8,366	13	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	46,854	13,580,789	0.003450	76,253	263	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,681	8,515,031	0.001607	56,030	90	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	22,531	13,498,637	0.001669	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,783	35,970,008	0.000355	733,073	260	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	146,262	0	0.000000	0	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	8	0	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	11	146,056	0.000075	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	73	0	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	907	691,366	0.001312	0	0	90.13
90.14	09014	WOUND CARE	119,101	3,832,589	0.031076	19	1	90.14
91.00	09100	EMERGENCY	839,088	30,953,463	0.027108	24,611	667	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,954,648	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,311,979	348,038,755		1,645,884	7,466	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Subprovider - IPF | 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
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	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Subprovider - IPF | 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	48,328,351	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,631,664	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
55.01	05501	ULTRA SOUND	0	0	0	8,442,283	0.000000	55.01
57.00	05700	CT SCAN	0	0	0	42,985,910	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	14,805,232	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	15,902,581	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	56,165,181	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	888,126	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,265,907	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,164,154	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,291,358	0.000000	67.00
67.01	06701	AUDIOLOGY	0	0	0	978,602	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,046,819	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	06901	CARDIOLOGY	0	0	0	13,580,789	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,515,031	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	13,498,637	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	35,970,008	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	146,056	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	691,366	0.000000	90.13
90.14	09014	WOUND CARE	0	0	0	3,832,589	0.000000	90.14
91.00	09100	EMERGENCY	0	0	0	30,953,463	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,954,648	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	348,038,755		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Subprovider - IPF | 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	12,019	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	48,473	0	12	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.000000	0	0	0	0	55.01
57.00	05700	CT SCAN	0.000000	47,651	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	6,110	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	8,065	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	564,324	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	1,736	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	5,300	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	33,913	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	19,941	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.000000	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	8,366	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.000000	76,253	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	56,030	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	733,073	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.000000	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.000000	19	0	0	0	90.14
91.00	09100	EMERGENCY	0.000000	24,611	0	1,213	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	238	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,645,884	0	1,463	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.104885	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237681	12	0	0	3	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.092265	0	0	0	0	55.01
57.00	05700	CT SCAN	0.026733	0	0	820	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.074484	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099663	0	0	0	0	59.00
60.00	06000	LABORATORY	0.156412	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.215731	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000971	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.420493	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.187302	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.260981	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.273687	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.143244	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.380964	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.397107	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071583	0	0	3,856	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.006730	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.285565	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.172012	0	0	150	0	90.14
91.00	09100	EMERGENCY	0.175948	1,213	0	0	213	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.515671	238	0	0	123	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.972146		0			95.00
200.00		Subtotal (see instructions)		1,463	0	4,826	339	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		1,463	0	4,826	339	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V

Component CCN: 15-S104 | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Subprovider - IPF | 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	55.01
57.00	05700	CT SCAN	0	22	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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	276	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	90.01
90.02	09002	CLINIC	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	90.03
90.04	09004	ENT CLINIC	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	90.13
90.14	09014	WOUND CARE	0	26	90.14
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	324	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	324	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/24/2019 2:03 pm
	Title XVIII	Skilled Nursing Facility	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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
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	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Skilled Nursing Facility | 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	48,328,351	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,631,664	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
55.01	05501	ULTRA SOUND	0	0	0	8,442,283	0.000000	55.01
57.00	05700	CT SCAN	0	0	0	42,985,910	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	14,805,232	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	15,902,581	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	56,165,181	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	888,126	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,265,907	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,164,154	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,291,358	0.000000	67.00
67.01	06701	AUDIOLOGY	0	0	0	978,602	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,046,819	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	06901	CARDIOLOGY	0	0	0	13,580,789	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,515,031	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	13,498,637	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	35,970,008	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	146,056	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	691,366	0.000000	90.13
90.14	09014	WOUND CARE	0	0	0	3,832,589	0.000000	90.14
91.00	09100	EMERGENCY	0	0	0	30,953,463	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,954,648	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	348,038,755		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Skilled Nursing Facility | 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	41,382	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	35,943	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.000000	2,524	0	0	0	55.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	29,217	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	211,684	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	32,941	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,149,993	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,242,206	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.000000	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	96,754	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.000000	324,938	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	114,070	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	912,638	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.000000	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.000000	69	0	0	0	90.14
91.00	09100	EMERGENCY	0.000000	1,265	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		4,195,624	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V
Component CCN: 15-5832 | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Skilled Nursing Facility | 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	0.104885	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237681	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.092265	0	0	0	0	55.01
57.00	05700	CT SCAN	0.026733	0	0	1,385	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.074484	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099663	0	0	0	0	59.00
60.00	06000	LABORATORY	0.156412	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.215731	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000971	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.420493	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.187302	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.260981	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.273687	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.143244	0	0	4	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.380964	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.397107	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071583	0	0	2,681	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.006730	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.285565	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.172012	0	0	0	0	90.14
91.00	09100	EMERGENCY	0.175948	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.515671	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.972146		0			95.00
200.00		Subtotal (see instructions)		0	0	4,070	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	4,070	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Skilled Nursing Facility | 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	55.01
57.00	05700	CT SCAN	0	37	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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIOLOGY	0	1	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	192	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	90.01
90.02	09002	CLINIC	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	90.03
90.04	09004	ENT CLINIC	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	90.13
90.14	09014	WOUND CARE	0	0	90.14
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	230	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	230	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 2:03 pm

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)	7,012	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,012	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,466	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)	2,263	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)	9,249,375	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)	9,249,375	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)	9,249,375	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,319.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,985,078	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)	2,985,078	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,633,255	1,776	1,482.69	834	1,236,563	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)	3,558,960	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,780,601	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)	381,462	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	197,636	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	579,098	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,201,503	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)	1,546	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,319.08	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,039,298	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/24/2019 2:03 pm
	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	875,485	9,249,375	0.094653	2,039,298	193,026	90.00
91.00	Nursing School cost	0	9,249,375	0.000000	2,039,298	0	91.00
92.00	Allied health cost	0	9,249,375	0.000000	2,039,298	0	92.00
93.00	All other Medical Education	0	9,249,375	0.000000	2,039,298	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Subprovider - IPF | 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)	3,133	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,133	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)	3,133	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)	2,558	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)	2,741,672	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)	2,741,672	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)	2,741,672	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)	875.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,238,480	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)	2,238,480	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Subprovider - IPF | 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)	213,324	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,451,804	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)	231,550	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	7,466	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	239,016	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,212,788	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: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Subprovider - IPF | 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	283,606	2,741,672	0.103443	0	0	90.00
91.00	Nursing School cost	0	2,741,672	0.000000	0	0	91.00
92.00	Allied health cost	0	2,741,672	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,741,672	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,027	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,027	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,027	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)	2,994	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)	3,004,527	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)	3,004,527	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)	3,004,527	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/24/2019 2:03 pm
	Title XVIII	Skilled Nursing Facility	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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	3,004,527	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	597.68	71.00
72.00	Program routine service cost (line 9 x line 71)	1,789,454	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,789,454	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,789,454	83.00
84.00	Program inpatient ancillary services (see instructions)	947,448	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,736,902	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: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Skilled Nursing Facility | 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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 2:03 pm

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)	7,012	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,012	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,466	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)	105	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)	1,060	15.00
16.00	Nursery days (title V or XIX only)	58	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)	9,249,375	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)	9,249,375	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)	9,249,375	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,319.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	138,503	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)	138,503	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/24/2019 2:03 pm
	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)	55,344	1,060	52.21	58	3,028	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,633,255	1,776	1,482.69	20	29,654	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)	107,071	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	278,256	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)	1,546	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,319.08	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,039,298	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/24/2019 2:03 pm

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	875,485	9,249,375	0.094653	2,039,298	193,026	90.00
91.00	Nursing School cost	0	9,249,375	0.000000	2,039,298	0	91.00
92.00	Allied health cost	0	9,249,375	0.000000	2,039,298	0	92.00
93.00	All other Medical Education	0	9,249,375	0.000000	2,039,298	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/24/2019 2:03 pm

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		2,311,850		30.00
31.00	03100	INTENSIVE CARE UNIT		1,973,650		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.104885	5,047,393	529,396	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237681	1,014,030	241,016	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.092265	61,493	5,674	55.01
57.00	05700	CT SCAN	0.026733	2,179,917	58,276	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.074484	369,800	27,544	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099663	630,920	62,879	59.00
60.00	06000	LABORATORY	0.156412	4,371,941	683,824	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.215731	161,160	34,767	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000971	618,537	601	64.00
66.00	06600	PHYSICAL THERAPY	0.420493	413,946	174,061	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.187302	289,225	54,172	67.00
67.01	06701	AUDIOLOGY	0.260981	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.273687	78,073	21,368	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.143244	3,910,273	560,123	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.380964	1,410,565	537,374	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.397107	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071583	3,412,199	244,255	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.006730	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.285565	0	0	90.13
90.14	09014	WOUND CARE	0.172012	582	100	90.14
91.00	09100	EMERGENCY	0.175948	1,838,782	323,530	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.515671	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)		25,808,836	3,558,960	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)		25,808,836		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Subprovider - IPF | 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
40.00	04000	SUBPROVIDER - IPF		3,049,439		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.104885	12,019	1,261	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237681	48,473	11,521	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.092265	0	0	55.01
57.00	05700	CT SCAN	0.026733	47,651	1,274	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.074484	6,110	455	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099663	8,065	804	59.00
60.00	06000	LABORATORY	0.156412	564,324	88,267	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.215731	1,736	375	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000971	5,300	5	64.00
66.00	06600	PHYSICAL THERAPY	0.420493	33,913	14,260	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.187302	19,941	3,735	67.00
67.01	06701	AUDIOLOGY	0.260981	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.273687	8,366	2,290	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.143244	76,253	10,923	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.380964	56,030	21,345	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.397107	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071583	733,073	52,476	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.006730	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.285565	0	0	90.13
90.14	09014	WOUND CARE	0.172012	19	3	90.14
91.00	09100	EMERGENCY	0.175948	24,611	4,330	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.515671	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)		1,645,884	213,324	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)		1,645,884		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/24/2019 2:03 pm
	Title XVIII	Skilled Nursing Facility	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
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.104885	41,382	4,340	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237681	35,943	8,543	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.092265	2,524	233	55.01
57.00	05700	CT SCAN	0.026733	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.074484	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099663	29,217	2,912	59.00
60.00	06000	LABORATORY	0.156412	211,684	33,110	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.215731	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000971	32,941	32	64.00
66.00	06600	PHYSICAL THERAPY	0.420493	1,149,993	483,564	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.187302	1,242,206	232,668	67.00
67.01	06701	AUDIOLOGY	0.260981	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.273687	96,754	26,480	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.143244	324,938	46,545	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.380964	114,070	43,457	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.397107	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071583	912,638	65,329	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.006730	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.285565	0	0	90.13
90.14	09014	WOUND CARE	0.172012	69	12	90.14
91.00	09100	EMERGENCY	0.175948	1,265	223	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.515671	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)		4,195,624	947,448	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)		4,195,624		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/24/2019 2:03 pm
	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		490,268		30.00
31.00	03100	INTENSIVE CARE UNIT		67,643		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		174,750		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.104885	113,047	11,857	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237681	17,539	4,169	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.092265	6,624	611	55.01
57.00	05700	CT SCAN	0.026733	53,595	1,433	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.074484	5,280	393	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099663	29,208	2,911	59.00
60.00	06000	LABORATORY	0.156412	142,345	22,264	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.215731	12,841	2,770	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000971	27,752	27	64.00
66.00	06600	PHYSICAL THERAPY	0.420493	5,112	2,150	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.187302	3,733	699	67.00
67.01	06701	AUDIOLOGY	0.260981	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.273687	113	31	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.143244	57,639	8,256	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.380964	83,238	31,711	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.397107	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071583	125,953	9,016	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.006730	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.285565	0	0	90.13
90.14	09014	WOUND CARE	0.172012	0	0	90.14
91.00	09100	EMERGENCY	0.175948	49,861	8,773	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.515671	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)		733,880	107,071	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)		733,880		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Date/Time Prepared: 5/24/2019 2:03 pm

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		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)	5,146,293	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,353,827	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)	81,440	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)	63.76	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.11	30.00
31.00	Percentage of Medicaid patient days (see instructions)	23.58	31.00
32.00	Sum of lines 30 and 31	25.69	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.41	33.00
34.00	Disproportionate share adjustment (see instructions)	169,165	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/24/2019 2:03 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	639,760	834,440	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	478,505	210,325	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	688,830		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	7,439,555		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)	7,439,555	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	541,302	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	7,980,857	59.00
60.00	Primary payer payments	5,831	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	7,975,026	61.00
62.00	Deductibles billed to program beneficiaries	873,440	62.00
63.00	Coinsurance billed to program beneficiaries	4,020	63.00
64.00	Allowable bad debts (see instructions)	77,359	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	50,283	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	18,128	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	7,147,849	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)	55,265	70.93
70.94	HRR adjustment amount (see instructions)	-29,681	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/24/2019 2:03 pm
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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2018	569,467	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)	2019	195,300	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)		7,938,200	71.00
71.01	Sequestration adjustment (see instructions)		158,764	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		7,729,820	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)		49,616	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		282,029	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0104

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

Worksheet E Part A Exhibit 4
Date/Time Prepared: 5/24/2019 2:03 pm

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		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	5,146,293	0	5,146,293		5,146,293	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,353,827	0		1,353,827	1,353,827	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	81,440	0	65,345	16,095	81,440	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	0.1041	0.1041	0.1041	0.1041		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	169,165	0	133,932	35,233	169,165	11.00
11.01	Uncompensated care payments	36.00	688,830	0	478,505	210,325	688,830	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	7,439,555	0	5,824,075	1,615,480	7,439,555	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	7,439,555	0	5,824,075	1,615,480	7,439,555	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	541,302	0	428,926	112,376	541,302	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: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/24/2019 2:03 pm
	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	6,253,001	1,727,856	7,980,857	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	529,368	0	419,216	110,152	529,368	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	11,934	0	9,710	2,224	11,934	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	541,302	0	428,926	112,376	541,302	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				0.091071	0.113030		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			569,467		569,467	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				195,300	195,300	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: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/24/2019 2:03 pm

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		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	5,146,293	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,353,827		6,500,120	6,500,120	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	81,440	0	81,440	81,440	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	0.1041	0.1041	0.1041		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	169,165	0	169,165	169,165	11.00
11.01	Uncompensated care payments	36.00	688,830	478,505	210,325	688,830	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	7,439,555	478,505	6,961,050	7,439,555	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	7,439,555	478,505	6,961,050	7,439,555	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	541,302	0	541,302	541,302	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			478,505	7,502,352	7,980,857	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/24/2019 2:03 pm

		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	529,368	0	529,368	529,368	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	11,934	0	11,934	11,934	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	541,302	0	541,302	541,302	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	569,467	569,467		569,467	28.00
29.00	Low volume adjustment on or after October 1	70.97	195,300		195,300	195,300	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	55,265	0	55,265	55,265	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	-29,681	0	-29,681	-29,681	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: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/24/2019 2:03 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,815	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	9,120,190	2.00
3.00	OPPS payments	11,424,579	3.00
4.00	Outlier payment (see instructions)	7,782	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)	2,815	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	41,652	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)	41,652	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)	41,652	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	38,837	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)	2,815	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)	11,432,361	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)	2,102,336	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)	9,332,840	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)	9,332,840	30.00
31.00	Primary payer payments	968	31.00
32.00	Subtotal (line 30 minus line 31)	9,331,872	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)	296,410	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	192,667	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	210,658	36.00
37.00	Subtotal (see instructions)	9,524,539	37.00
38.00	MSP-LCC reconciliation amount from PS&R	19	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)	9,524,520	40.00
40.01	Sequestration adjustment (see instructions)	190,490	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	9,148,470	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	185,560	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: 15-0104 Component CCN: 15-S104	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/24/2019 2:03 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	324	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	339	2.00
3.00	OPPS payments	409	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)	324	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	4,826	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)	4,826	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)	4,826	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	4,502	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)	324	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)	409	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)	733	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)	733	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	733	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)	733	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)	733	40.00
40.01	Sequestration adjustment (see instructions)	15	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,347	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-629	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: 15-0104 Component CCN: 15-5832	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/24/2019 2:03 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	230	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	230	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	4,070	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)	4,070	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)	4,070	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,840	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)	230	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)		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)	230	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)	230	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	230	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)	230	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	230	40.00
40.01	Sequestration adjustment (see instructions)	5	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	798	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-573	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part I Date/Time Prepared: 5/24/2019 2:03 pm
	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		7,729,820		9,148,470	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)		7,729,820		9,148,470	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		49,616		185,560	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		7,779,436		9,334,030	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: 15-0104 Component CCN: 15-S104	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part I Date/Time Prepared: 5/24/2019 2:03 pm
	Title XVIII	Subprovider - IPF	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		2,342,681		1,347	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)		2,342,681		1,347	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		2,836		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		629	6.02
7.00	Total Medicare program liability (see instructions)		2,345,517		718	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: 15-0104 Component CCN: 15-5832	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part I Date/Time Prepared: 5/24/2019 2:03 pm
	Title XVIII	Skilled Nursing Facility	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		1,212,562		798	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)		1,212,562		798	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		5,593		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		573	6.02
7.00	Total Medicare program liability (see instructions)		1,218,155		225	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: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/24/2019 2:03 pm
	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: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part III Date/Time Prepared: 5/24/2019 2:03 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	0	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	0	3.00
4.00	Outlier Payments	0	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)	14.975342	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)	0	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)	0	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	0	19.00
20.00	Deductibles	0	20.00
21.00	Subtotal (line 19 minus line 20)	0	21.00
22.00	Coinsurance	0	22.00
23.00	Subtotal (line 21 minus line 22)	0	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	4,452	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	2,894	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)	2,894	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	2,894	32.00
32.01	Sequestration adjustment (see instructions)	58	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	7,729,820	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)	-7,726,984	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	0	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: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-3 Part II | Date/Time Prepared: 5/24/2019 2:03 pm

Title XVIII | Subprovider - IPF | PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,555,467	1.00
2.00	Net IPF PPS Outlier Payments	13,459	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	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	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	8.583562	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,568,926	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,568,926	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,568,926	18.00
19.00	Deductibles	155,344	19.00
20.00	Subtotal (line 18 minus line 19)	2,413,582	20.00
21.00	Coinsurance	23,091	21.00
22.00	Subtotal (line 20 minus line 21)	2,390,491	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	4,452	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	2,894	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,393,385	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,393,385	31.00
31.01	Sequestration adjustment (see instructions)	47,868	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	2,342,681	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	2,836	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	13,459	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: 15-0104 Component CCN: 15-5832	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VI Date/Time Prepared: 5/24/2019 2:03 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,419,716	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,419,716	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	182,408	7.00
8.00	Allowable bad debts (see instructions)	8,780	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	5,707	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,243,015	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	1,243,015	15.00
15.01	Sequestration adjustment (see instructions)	24,860	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	1,212,562	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	5,593	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-3 Part VII Date/Time Prepared: 5/24/2019 2:03 pm

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	278,256		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)	278,256	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)	278,256	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	732,660		8.00
9.00	Ancillary service charges	733,880	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)	1,466,540	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)	1,466,540	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,188,284	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)	278,256	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)	278,256	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)	278,256	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)	278,256	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	278,256	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)	278,256	0	40.00
41.00	Interim payments	586,485	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-308,229	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: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet G Date/Time Prepared: 5/24/2019 2:03 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	30,315,517	0	0	0	1.00
2.00	Temporary investments	11,162,657	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	18,140,015	0	0	0	4.00
5.00	Other receivable	2,093,813	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,383,251	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,590,837	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	66,686,090	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	15,755,407	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	29,163,673	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	149,608,340	0	0	0	23.00
24.00	Accumulated depreciation	-80,097,717	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)	114,429,703	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	21,277,961	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)	21,277,961	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	202,393,754	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,408,193	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,888,404	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,428,880	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	21,725,477	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	46,381,044	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	46,381,044	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	68,106,521	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	134,287,233				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)	134,287,233	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	202,393,754	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/24/2019 2:03 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		129,060,668		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,226,565				2.00
3.00	Total (sum of line 1 and line 2)		134,287,233		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)		134,287,233		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		134,287,233		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/24/2019 2:03 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	16,037,658		16,037,658	1.00
2.00	SUBPROVIDER - IPF	3,780,153		3,780,153	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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	2,784,782		2,784,782	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)	22,602,593		22,602,593	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	4,588,887		4,588,887	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)	4,588,887		4,588,887	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	27,191,480		27,191,480	17.00
18.00	Ancillary services	58,447,830	250,012,803	308,460,633	18.00
19.00	Outpatient services	8,041,819	31,536,303	39,578,122	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	4,515	3,959,151	3,963,666	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	EH&S, DIETARY, PHYSICIAN PRIVATE OFF	2,337	55,551,757	55,554,094	27.00
27.01	PROFESSIONAL FEE	103,173	2,221,869	2,325,042	27.01
27.02	SELF INSURED	1,237,124	8,229,879	9,467,003	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	95,028,278	351,511,762	446,540,040	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		142,966,952		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)		142,966,952		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 Date/Time Prepared: 5/24/2019 2:03 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	446,540,040	1.00
2.00	Less contractual allowances and discounts on patients' accounts	301,249,006	2.00
3.00	Net patient revenues (line 1 minus line 2)	145,291,034	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	142,966,952	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,324,082	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	3,126,907	24.00
24.01	NONOPERATING INCOME	-224,424	24.01
25.00	Total other income (sum of lines 6-24)	2,902,483	25.00
26.00	Total (line 5 plus line 25)	5,226,565	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,226,565	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/24/2019 2:03 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	529,368	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	11,934	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)	20.41	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	541,302	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