

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: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 3:05 pm
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PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 5/29/2019 Time: 3:05 pm
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

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

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 COMMUNITY HOSPITAL OF INDIANA, INC. (15-0169) 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) HOLLY MILLARD
 Officer or Administrator of Provider(s)

NETWORK SENIOR VICE PRESIDENT OF FIN
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	217,404	19,002	0	0	1.00
2.00 Subprovider - IPF	0	3,506	20,742		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
200.00 Total	0	220,910	39,744	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-0169		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:05 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00 Street: 7150 CLEARVISTA DRIVE		PO Box:										
2.00 City: INDIANAPOLIS		State: IN		Zip Code: 46256		County: MARION						
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
				V	XVIII	XIX						
Hospital and Hospital-Based Component Identification:												
3.00 Hospital		COMMUNITY HOSPITAL OF INDIANA, INC.		150169	26900	1	02/25/2008	N	P	P	3.00	
4.00 Subprovider - IPF		COMMUNITY MENTAL HEALTH		15S169	26900	4	01/01/2010	N	P	O	4.00	
5.00 Subprovider - IRF											5.00	
6.00 Subprovider - (Other)											6.00	
7.00 Swing Beds - SNF											7.00	
8.00 Swing Beds - NF											8.00	
9.00 Hospital-Based SNF											9.00	
10.00 Hospital-Based NF											10.00	
11.00 Hospital-Based OLTC											11.00	
12.00 Hospital-Based HHA											12.00	
13.00 Separately Certified ASC											13.00	
14.00 Hospital-Based Hospice											14.00	
15.00 Hospital-Based Health Clinic - RHC											15.00	
16.00 Hospital-Based Health Clinic - FQHC											16.00	
17.00 Hospital-Based (CMHC) I											17.00	
18.00 Renal Dialysis											18.00	
19.00 Other											19.00	
							From:	To:				
							1.00	2.00				
20.00 Cost Reporting Period (mm/dd/yyyy)							01/01/2018	12/31/2018		20.00		
21.00 Type of Control (see instructions)							2			21.00		
							1.00	2.00	3.00			
Inpatient PPS Information												
22.00 Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						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)						N	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 days	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.		1,901	1,768	8	41	21,632	47		24.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0169			Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:05 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	0	25.00	
						Urban/Rural	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 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	Y	40.00	
						V	XVII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					Y			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.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria 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	

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	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. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0169

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

Worksheet S-2
Part I
Date/Time Prepared:
5/29/2019 3:05 pm

		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	4.12	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)	FAMILY PRACTICE	1350	0.00	1.27	0.000000	67.00	
							1.00 2.00 3.00	
70.00	Inpatient Psychiatric Facility PPS 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)					N	0	76.00

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						1.00			
Long Term Care Hospital PPS									
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.					N		81.00	
TEFRA Providers									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					N		87.00	
						V	XIX		
						1.00	2.00		
Title V and XIX Services									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.					N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.					N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? 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
						1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.						N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:05 pm		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	963,025	0			118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				140.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0169		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 3:05 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
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				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					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.	Y					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					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	04/29/2014	Y	04/29/2014		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: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 3:05 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		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved 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.	RONALD		HELMS	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH NETWORK			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-5501		RHELMS@COMMUNITY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 3:05 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.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0169

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2019 3:05 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	214	78,110	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)		214	78,110	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	24	8,760	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 NEONATAL INTENSIVE CARE UNIT	35.00	42	15,330	0.00	0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		280	102,200	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	18	6,570		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		298				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: 15-0169

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2019 3:05 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)	19,318	1,012	57,068			1.00
2.00 HMO and other (see instructions)	8,057	20,445				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	19,318	1,012	57,068			7.00
8.00 INTENSIVE CARE UNIT	2,041	0	5,973			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 NEONATAL INTENSIVE CARE UNIT	0	605	12,362			12.00
13.00 NURSERY		3,288	7,653			13.00
14.00 Total (see instructions)	21,359	4,905	83,056	3.81	1,464.80	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	2,614	0	3,733	1.58	21.85	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			480			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)				5.39	1,486.65	27.00
28.00 Observation Bed Days		1,844	6,455			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			2,022			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	47	1,344			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: 15-0169

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2019 3:05 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	4,710	216	17,414	1.00
2.00 HMO and other (see instructions)			1,578	2,886		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 NEONATAL INTENSIVE CARE UNIT						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	4,710	216	17,414	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	231	0	370	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0169

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2019 3:05 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	100,308,509	-576,827	99,731,682	3,092,227.00	32.25
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		89,273	0	89,273	572.00	156.07
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		367,344	0	367,344	6,416.00	57.25
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,154,440	-17,248	2,137,192	64,515.00	33.13
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		1,213,089	0	1,213,089	11,573.00	104.82
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		4,087,837	0	4,087,837	34,315.00	119.13
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		31,026,523	0	31,026,523	711,641.00	43.60
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		24,705,225	0	24,705,225		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		532,111	0	532,111		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		5,692	0	5,692		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		63,847	0	63,847		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		7,170,944	0	7,170,944		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	162,789	0	162,789	3,475.00	46.85
27.00	Administrative & General	5.00	5,558,717	-15,633	5,543,084	140,068.00	39.57

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0169

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2019 3:05 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	
28.00	Administrative & General under contract (see inst.)		8,870,574	0	8,870,574	97,067.00	91.39	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	3,040,788	-19,655	3,021,133	136,751.00	22.09	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	2,920,542	-31,881	2,888,661	188,502.00	15.32	32.00
33.00	Housekeeping under contract (see instructions)		394,740	0	394,740	9,911.00	39.83	33.00
34.00	Dietary	10.00	2,418,178	-1,782,720	635,458	36,700.00	17.31	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,774,879	1,774,879	101,258.00	17.53	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,027,729	-2,347	2,025,382	60,492.00	33.48	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	4,643,917	-28,822	4,615,095	110,414.00	41.80	40.00
41.00	Medical Records & Medical Records Library	16.00	382,171	-296	381,875	9,985.00	38.24	41.00
42.00	Social Service	17.00	1,436,425	-9,377	1,427,048	41,106.00	34.72	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0169

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

Worksheet S-3
Part III
Date/Time Prepared:
5/29/2019 3:05 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation 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)	109,206,479	-576,827	108,629,652	3,192,789.00	34.02	1.00
2.00	Excluded area salaries (see instructions)	2,154,440	-17,248	2,137,192	64,515.00	33.13	2.00
3.00	Subtotal salaries (line 1 minus line 2)	107,052,039	-559,579	106,492,460	3,128,274.00	34.04	3.00
4.00	Subtotal other wages & related costs (see inst.)	36,327,449	0	36,327,449	757,529.00	47.96	4.00
5.00	Subtotal wage-related costs (see inst.)	31,881,861	0	31,881,861	0.00	29.94	5.00
6.00	Total (sum of lines 3 thru 5)	175,261,349	-559,579	174,701,770	3,885,803.00	44.96	6.00
7.00	Total overhead cost (see instructions)	31,856,570	-115,852	31,740,718	935,729.00	33.92	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2019 3:05 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	3,010,227	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	616,145	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	10,290,665	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	2,944,043	9.00
10.00	Dental, Hearing and Vision Plan	110,082	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	59,783	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)	863,384	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	169,865	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	7,120,637	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	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	122,045	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	25,306,876	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part V Date/Time Prepared: 5/29/2019 3:05 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	1,213,089	25,306,876	1.00
2.00	Hospital	1,213,089	24,774,772	2.00
3.00	Subprovider - IPF	0	374,753	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	157,351	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/29/2019 3:05 pm
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			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)		0.213260	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		39,781,993	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		286,695,250	6.00	
7.00	Medicaid cost (line 1 times line 6)		61,140,629	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)		21,358,636	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)		21,358,636	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)	28,658,911	2,809,447	31,468,358	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	6,111,799	2,809,447	8,921,246	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)	6,111,799	2,809,447	8,921,246	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)			1,959,218	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			285,931	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			439,895	27.01
28.00	Non-Medicare bad debt expense (see instructions)			1,519,323	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			477,975	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			9,399,221	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			30,757,857	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0169

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

Worksheet A
Date/Time Prepared:
5/29/2019 3:05 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	19,622,377	19,622,377	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	10,233,594	10,233,594	2.00	
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	162,789	234,722	397,511	-89,305	308,206	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,558,717	121,461,273	127,019,990	-19,200,100	107,819,890	5.00
7.00	00700	OPERATION OF PLANT	3,040,788	7,384,690	10,425,478	-116,126	10,309,352	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	877,009	877,009	-80	876,929	8.00
9.00	00900	HOUSEKEEPING	2,920,542	1,903,124	4,823,666	-7,777	4,815,889	9.00
10.00	01000	DIETARY	2,418,178	2,900,204	5,318,382	-3,731,623	1,586,759	10.00
11.00	01100	CAFETERIA	0	0	0	3,694,674	3,694,674	11.00
13.00	01300	NURSING ADMINISTRATION	2,027,729	521,783	2,549,512	-4,523	2,544,989	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	400,380	400,380	-1,020,674	-620,294	14.00
15.00	01500	PHARMACY	4,643,917	14,410,327	19,054,244	-14,122,654	4,931,590	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	382,171	60,101	442,272	-80	442,192	16.00
17.00	01700	SOCIAL SERVICE	1,436,425	394,059	1,830,484	-36	1,830,448	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,479,369	17,025,709	49,505,078	-12,114,532	37,390,546	30.00
31.00	03100	INTENSIVE CARE UNIT	4,325,430	2,288,132	6,613,562	-826,676	5,786,886	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,714,123	2,599,208	9,313,331	-378,693	8,934,638	35.00
40.00	04000	SUBPROVIDER - I PF	1,623,226	521,776	2,145,002	-23,210	2,121,792	40.00
43.00	04300	NURSERY	0	0	0	2,407,581	2,407,581	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,870,875	30,551,276	35,422,151	-25,712,121	9,710,030	50.00
51.00	05100	RECOVERY ROOM	2,381,007	1,208,877	3,589,884	-360,033	3,229,851	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	532,668	19,476	552,144	5,994,819	6,546,963	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,516,476	2,240,326	5,756,802	-1,510,995	4,245,807	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	420,136	2,757,626	3,177,762	-2,380,516	797,246	55.00
57.00	05700	CT SCAN	825,623	914,253	1,739,876	-347,496	1,392,380	57.00
58.00	05800	MRI	470,979	862,832	1,333,811	-351,297	982,514	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,293	1,293	-1,248	45	59.00
60.00	06000	LABORATORY	31,877	10,585,139	10,617,016	-12,120	10,604,896	60.00
64.00	06400	INTRAVENOUS THERAPY	291,332	193,521	484,853	-100,201	384,652	64.00
65.00	06500	RESPIRATORY THERAPY	2,744,912	1,785,579	4,530,491	-723,188	3,807,303	65.00
66.00	06600	PHYSICAL THERAPY	5,794,012	2,844,300	8,638,312	-3,001,236	5,637,076	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,687,272	1,687,272	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	320,023	320,023	68.00
69.00	06900	ELECTROCARDIOLOGY	27,517	841,420	868,937	-9,852	859,085	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	945,855	756,758	1,702,613	-291,344	1,411,269	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	19,073,633	19,073,633	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,842,066	12,842,066	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,275,333	14,275,333	73.00
74.00	07400	RENAL DIALYSIS	0	1,185,376	1,185,376	-2,636	1,182,740	74.00
76.00	03330	ENDOSCOPY	1,136,452	2,430,410	3,566,862	-1,718,304	1,848,558	76.00
76.06	03954	IMAGING CENTER	1,392,569	2,356,004	3,748,573	-1,141,663	2,606,910	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	8,016,905	8,016,905	-254,255	7,762,650	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.26	04975	SPI NE CENTER	185,515	62,836	248,351	-721	247,630	90.26
91.00	09100	EMERGENCY	6,476,086	3,531,783	10,007,869	-554,255	9,453,614	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,777,295	246,128,487	345,905,782	41,802	345,947,584	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	116,952	116,952	0	116,952	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	PAVILLIONS	0	56,947	56,947	15,857	72,804	194.06
194.08	07958	OTHER NRCC	531,214	1,166,131	1,697,345	-57,659	1,639,686	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	100,308,509	247,468,517	347,777,026	0	347,777,026	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0169

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

Worksheet A
Date/Time Prepared:
5/29/2019 3:05 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-6,392,494	13,229,883	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,728,817	15,962,411	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,219,967	5,528,173	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-44,354,021	63,465,869	5.00
7.00	00700	OPERATION OF PLANT	554,143	10,863,495	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	876,929	8.00
9.00	00900	HOUSEKEEPING	0	4,815,889	9.00
10.00	01000	DIETARY	-24,144	1,562,615	10.00
11.00	01100	CAFETERIA	-2,423,399	1,271,275	11.00
13.00	01300	NURSING ADMINISTRATION	4,549,434	7,094,423	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,330,339	710,045	14.00
15.00	01500	PHARMACY	-47,628	4,883,962	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,667,433	3,109,625	16.00
17.00	01700	SOCIAL SERVICE	0	1,830,448	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	406,401	406,401	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	621,282	621,282	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	834,265	38,224,811	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,786,886	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-467,403	8,467,235	35.00
40.00	04000	SUBPROVIDER - I PF	0	2,121,792	40.00
43.00	04300	NURSERY	0	2,407,581	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-2,500	9,707,530	50.00
51.00	05100	RECOVERY ROOM	0	3,229,851	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,546,963	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	125	4,245,932	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	797,246	55.00
57.00	05700	CT SCAN	0	1,392,380	57.00
58.00	05800	MRI	-116,800	865,714	58.00
59.00	05900	CARDIAC CATHETERIZATION	127,131	127,176	59.00
60.00	06000	LABORATORY	-1,193,952	9,410,944	60.00
64.00	06400	INTRAVENOUS THERAPY	0	384,652	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,807,303	65.00
66.00	06600	PHYSICAL THERAPY	-820	5,636,256	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,687,272	67.00
68.00	06800	SPEECH PATHOLOGY	0	320,023	68.00
69.00	06900	ELECTROCARDIOLOGY	-245,222	613,863	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	361,911	1,773,180	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	19,073,633	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,842,066	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	454,036	14,729,369	73.00
74.00	07400	RENAL DIALYSIS	0	1,182,740	74.00
76.00	03330	ENDOSCOPY	0	1,848,558	76.00
76.06	03954	IMAGING CENTER	0	2,606,910	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	7,762,650	76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.26	04975	SPINE CENTER	0	247,630	90.26
91.00	09100	EMERGENCY	-32,879	9,420,735	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-32,445,978	313,501,606	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	116,952	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HOME OFFICE	0	0	194.00
194.06	07956	PAVILLIONS	0	72,804	194.06
194.08	07958	OTHER NRCC	0	1,639,686	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	-32,445,978	315,331,048	200.00

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6

Date/Time Prepared:
5/29/2019 3:05 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - Chargeable Medical Supplies					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	712,092	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	19,073,633	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
	0		0	19,785,725	
B - Implantable Device Recl ass					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	12,842,066	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	12,842,066	
C - Drugs Charges to Pat					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	393	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	14,275,333	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
	0		0	14,275,726	
D - Depreciation Expense					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,877,184	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6

Date/Time Prepared:
5/29/2019 3:05 pm

						Increases			
Cost Center		Line #	Salary	Other					
2.00		3.00	4.00	5.00					
14.00		0.00	0	0				14.00	
15.00		0.00	0	0				15.00	
16.00		0.00	0	0				16.00	
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	
0			0	13,877,184					
E - Interest Expense									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	10,779,865				1.00	
0			0	10,779,865					
F - Other Capital Rental									
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,830,975				1.00	
2.00	OPERATION OF PLANT	7.00	0	14,139				2.00	
3.00	EMERGENCY	91.00	0	30,244				3.00	
4.00	PAVILLIONS	194.06	0	37,644				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	
0			0	4,913,002					
G - STD BENEFITS									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,633				1.00	
2.00	OPERATION OF PLANT	7.00	0	19,655				2.00	
3.00	HOUSEKEEPING	9.00	0	31,881				3.00	
4.00	DIETARY	10.00	0	7,841				4.00	
5.00	NURSING ADMINISTRATION	13.00	0	2,347				5.00	
6.00	PHARMACY	15.00	0	28,822				6.00	
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	296				7.00	
8.00	SOCIAL SERVICE	17.00	0	9,377				8.00	
9.00	ADULTS & PEDIATRICS	30.00	0	169,224				9.00	
10.00	INTENSIVE CARE UNIT	31.00	0	17,038				10.00	
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	77,126				11.00	
12.00	SUBPROVIDER - IPF	40.00	0	17,248				12.00	
13.00	OPERATING ROOM	50.00	0	32,926				13.00	
14.00	RECOVERY ROOM	51.00	0	11,385				14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,086				15.00	
16.00	CT SCAN	57.00	0	2,785				16.00	
17.00	MRI	58.00	0	920				17.00	
18.00	LABORATORY	60.00	0	6,556				18.00	
19.00	RESPIRATORY THERAPY	65.00	0	22,640				19.00	
20.00	PHYSICAL THERAPY	66.00	0	39,832				20.00	
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,725				21.00	

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6

Date/Time Prepared:
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Increases						
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
22.00	ENDOSCOPY	76.00	0	8,274		22.00
23.00	IMAGING CENTER	76.06	0	9,378		23.00
24.00	EMERGENCY	91.00	0	25,832		24.00
	0		0	576,827		
H - Labor and Delivery						
1.00	NURSERY	43.00	1,696,926	710,655		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	4,225,304	1,769,515		2.00
	0		5,922,230	2,480,170		
I - Cafeteria Reclass						
1.00	CAFETERIA	11.00	1,774,879	1,919,795		1.00
	0		1,774,879	1,919,795		
J - Therapy						
1.00	OCCUPATIONAL THERAPY	67.00	1,167,985	519,287		1.00
2.00	SPEECH PATHOLOGY	68.00	221,530	98,493		2.00
	0		1,389,515	617,780		
K - Depreciation by CC						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,474,565		1.00
	0		0	8,474,565		
L - Capital Insurance Costs						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	367,947		1.00
	0		0	367,947		
M - Radiology Support						
1.00	RADIOLOGY-THERAPEUTIC	55.00	98,353	37,782		1.00
2.00	CT SCAN	57.00	209,853	80,614		2.00
3.00	MRI	58.00	51,514	19,789		3.00
	0		359,720	138,185		
500.00	Grand Total: Increases		9,446,344	91,048,837		500.00

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6
Date/Time Prepared:
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Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - Chargeable Medical Supplies						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	118	0	1.00
2.00	OPERATION OF PLANT	7.00	0	64,816	0	2.00
3.00	DIETARY	10.00	0	935	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	1,133	0	4.00
5.00	PHARMACY	15.00	0	402,290	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	2,243,582	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	460,422	0	7.00
8.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	207,412	0	8.00
9.00	SUBPROVIDER - IPF	40.00	0	5,334	0	9.00
10.00	OPERATING ROOM	50.00	0	11,908,433	0	10.00
11.00	RECOVERY ROOM	51.00	0	346,658	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	360,878	0	12.00
13.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,225,063	0	13.00
14.00	CT SCAN	57.00	0	214,213	0	14.00
15.00	MRI	58.00	0	21,098	0	15.00
16.00	LABORATORY	60.00	0	1,312	0	16.00
17.00	INTRAVENOUS THERAPY	64.00	0	96,563	0	17.00
18.00	RESPIRATORY THERAPY	65.00	0	470,989	0	18.00
19.00	PHYSICAL THERAPY	66.00	0	85,968	0	19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	77,991	0	20.00
21.00	RENAL DIALYSIS	74.00	0	2,636	0	21.00
22.00	ENDOSCOPY	76.00	0	1,113,560	0	22.00
23.00	IMAGING CENTER	76.06	0	93,617	0	23.00
24.00	BREAST DIAGNOSTIC CENTER	76.07	0	750	0	24.00
25.00	SPINE CENTER	90.26	0	242	0	25.00
26.00	EMERGENCY	91.00	0	377,348	0	26.00
27.00	PAVILLIONS	194.06	0	1,527	0	27.00
28.00	OTHER NRCC	194.08	0	837	0	28.00
0			0	19,785,725		
B - Implantable Device Recl ass						
1.00	OPERATING ROOM	50.00	0	11,962,339	0	1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00	0	686,597	0	2.00
3.00	ENDOSCOPY	76.00	0	193,130	0	3.00
0			0	12,842,066		
C - Drugs Charges to Pat						
1.00	OPERATION OF PLANT	7.00	0	2,780	0	1.00
2.00	DIETARY	10.00	0	374	0	2.00
3.00	PHARMACY	15.00	0	13,133,944	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	88,935	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	21,290	0	5.00
6.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	2,599	0	6.00
7.00	SUBPROVIDER - IPF	40.00	0	636	0	7.00
8.00	OPERATING ROOM	50.00	0	319,894	0	8.00
9.00	RECOVERY ROOM	51.00	0	3,358	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	208,553	0	10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	31,936	0	11.00
12.00	CT SCAN	57.00	0	178,432	0	12.00
13.00	MRI	58.00	0	85,810	0	13.00
14.00	INTRAVENOUS THERAPY	64.00	0	622	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	14,225	0	15.00
16.00	PHYSICAL THERAPY	66.00	0	3,590	0	16.00
17.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,050	0	17.00
18.00	ENDOSCOPY	76.00	0	4,571	0	18.00
19.00	IMAGING CENTER	76.06	0	150,844	0	19.00
20.00	EMERGENCY	91.00	0	22,128	0	20.00
21.00	OTHER NRCC	194.08	0	155	0	21.00
0			0	14,275,726		
D - Depreciation Expense						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,307	9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	7,858,205	0	2.00
3.00	OPERATION OF PLANT	7.00	0	62,669	0	3.00
4.00	HOUSEKEEPING	9.00	0	6,922	0	4.00
5.00	DIETARY	10.00	0	34,697	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	853	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	61,169	0	7.00
8.00	PHARMACY	15.00	0	54,590	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	1,377,944	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	344,422	0	10.00
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	165,590	0	11.00
12.00	SUBPROVIDER - IPF	40.00	0	16,841	0	12.00
13.00	OPERATING ROOM	50.00	0	860,411	0	13.00
14.00	RECOVERY ROOM	51.00	0	9,766	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	442,188	0	15.00

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6
Date/Time Prepared:
5/29/2019 3:05 pm

Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	572,375	0	16.00	
17.00	CT SCAN	57.00	0	245,318	0	17.00	
18.00	MRI	58.00	0	282,568	0	18.00	
19.00	CARDIAC CATHETERIZATION	59.00	0	1,248	0	19.00	
20.00	LABORATORY	60.00	0	3,232	0	20.00	
21.00	INTRAVENOUS THERAPY	64.00	0	2,856	0	21.00	
22.00	RESPIRATORY THERAPY	65.00	0	120,228	0	22.00	
23.00	PHYSICAL THERAPY	66.00	0	179,575	0	23.00	
24.00	ELECTROCARDIOLOGY	69.00	0	9,852	0	24.00	
25.00	ELECTROENCEPHALOGRAPHY	70.00	0	69,318	0	25.00	
26.00	ENDOSCOPY	76.00	0	406,883	0	26.00	
27.00	IMAGING CENTER	76.06	0	465,788	0	27.00	
28.00	BREAST DIAGNOSTIC CENTER	76.07	0	14,086	0	28.00	
29.00	EMERGENCY	91.00	0	185,023	0	29.00	
30.00	PAVILLIONS	194.06	0	20,260	0	30.00	
			0	13,877,184			
E - Interest Expense							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,779,865	11	1.00	
			0	10,779,865			
F - Other Capital Rental							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	86,998	10	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	193,965	0	2.00	
3.00	LAUNDRY & LINEN SERVICE	8.00	0	80	0	3.00	
4.00	HOUSEKEEPING	9.00	0	855	0	4.00	
5.00	DIETARY	10.00	0	943	0	5.00	
6.00	NURSING ADMINISTRATION	13.00	0	2,537	0	6.00	
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,671,990	0	7.00	
8.00	PHARMACY	15.00	0	531,830	0	8.00	
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	80	0	9.00	
10.00	SOCIAL SERVICE	17.00	0	36	0	10.00	
11.00	ADULTS & PEDIATRICS	30.00	0	1,671	0	11.00	
12.00	INTENSIVE CARE UNIT	31.00	0	542	0	12.00	
13.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	3,092	0	13.00	
14.00	SUBPROVIDER - IPF	40.00	0	399	0	14.00	
15.00	OPERATING ROOM	50.00	0	661,044	0	15.00	
16.00	RECOVERY ROOM	51.00	0	251	0	16.00	
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,471	0	17.00	
18.00	RADIOLOGY-THERAPEUTIC	55.00	0	680	0	18.00	
19.00	MRI	58.00	0	33,124	0	19.00	
20.00	LABORATORY	60.00	0	7,576	0	20.00	
21.00	INTRAVENOUS THERAPY	64.00	0	160	0	21.00	
22.00	RESPIRATORY THERAPY	65.00	0	117,746	0	22.00	
23.00	PHYSICAL THERAPY	66.00	0	724,808	0	23.00	
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	142,985	0	24.00	
25.00	ENDOSCOPY	76.00	0	160	0	25.00	
26.00	IMAGING CENTER	76.06	0	431,414	0	26.00	
27.00	BREAST DIAGNOSTIC CENTER	76.07	0	239,419	0	27.00	
28.00	SPINE CENTER	90.26	0	479	0	28.00	
29.00	OTHER NRCC	194.08	0	56,667	0	29.00	
			0	4,913,002			
G - STD BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	15,633	0	0	1.00	
2.00	OPERATION OF PLANT	7.00	19,655	0	0	2.00	
3.00	HOUSEKEEPING	9.00	31,881	0	0	3.00	
4.00	DIETARY	10.00	7,841	0	0	4.00	
5.00	NURSING ADMINISTRATION	13.00	2,347	0	0	5.00	
6.00	PHARMACY	15.00	28,822	0	0	6.00	
7.00	MEDICAL RECORDS & LIBRARY	16.00	296	0	0	7.00	
8.00	SOCIAL SERVICE	17.00	9,377	0	0	8.00	
9.00	ADULTS & PEDIATRICS	30.00	169,224	0	0	9.00	
10.00	INTENSIVE CARE UNIT	31.00	17,038	0	0	10.00	
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	77,126	0	0	11.00	
12.00	SUBPROVIDER - IPF	40.00	17,248	0	0	12.00	
13.00	OPERATING ROOM	50.00	32,926	0	0	13.00	
14.00	RECOVERY ROOM	51.00	11,385	0	0	14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	18,086	0	0	15.00	
16.00	CT SCAN	57.00	2,785	0	0	16.00	
17.00	MRI	58.00	920	0	0	17.00	
18.00	LABORATORY	60.00	6,556	0	0	18.00	
19.00	RESPIRATORY THERAPY	65.00	22,640	0	0	19.00	
20.00	PHYSICAL THERAPY	66.00	39,832	0	0	20.00	
21.00	ELECTROENCEPHALOGRAPHY	70.00	1,725	0	0	21.00	
22.00	ENDOSCOPY	76.00	8,274	0	0	22.00	
23.00	IMAGING CENTER	76.06	9,378	0	0	23.00	

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6

Date/Time Prepared:
5/29/2019 3:05 pm

		Decreases						
	Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00			
24.00	EMERGENCY	91.00	25,832	0	0	0		24.00
			576,827	0				
H - Labor and Delivery								
1.00	ADULTS & PEDIATRICS	30.00	5,922,230	2,480,170		0		1.00
2.00		0.00	0	0		0		2.00
			5,922,230	2,480,170				
I - Cafeteria Reclass								
1.00	DIETARY	10.00	1,774,879	1,919,795		0		1.00
			1,774,879	1,919,795				
J - Therapy								
1.00	PHYSICAL THERAPY	66.00	1,389,515	617,780		0		1.00
2.00		0.00	0	0		0		2.00
			1,389,515	617,780				
K - Depreciation by CC								
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,474,565		9		1.00
			0	8,474,565				
L - Capital Insurance Costs								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	367,947		12		1.00
			0	367,947				
M - Radiology Support								
1.00	RADIOLOGY-DIAGNOSTIC	54.00	359,720	138,185		0		1.00
2.00		0.00	0	0		0		2.00
3.00		0.00	0	0		0		3.00
			359,720	138,185				
500.00	Grand Total: Decreases		10,023,171	90,472,010				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0169

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

Worksheet A-7
Part I
Date/Time Prepared:
5/29/2019 3:05 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	497,000	757,312	0	757,312	0	1.00
2.00	Land Improvements	2,722,362	0	0	0	0	2.00
3.00	Buildings and Fixtures	174,593,288	3,121,087	0	3,121,087	658,831	3.00
4.00	Building Improvements	1,751,624	845,503	0	845,503	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	108,146,114	5,301,513	0	5,301,513	1,831,439	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	287,710,388	10,025,415	0	10,025,415	2,490,270	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	287,710,388	10,025,415	0	10,025,415	2,490,270	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,254,312	0				1.00
2.00	Land Improvements	2,722,362	0				2.00
3.00	Buildings and Fixtures	177,055,544	0				3.00
4.00	Building Improvements	2,597,127	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	111,616,188	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	295,245,533	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	295,245,533	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0169

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

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2019 3:05 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	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	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	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0169

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

Worksheet A-7
Part III
Date/Time Prepared:
5/29/2019 3:05 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	CAP REL COSTS-BLDG & FIXT	179,359,840	0	179,359,840	0.714496	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	71,670,112	0	71,670,112	0.285504	0	2.00
3.00	Total (sum of lines 1-2)	251,029,952	0	251,029,952	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	8,474,565	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	11,131,436	4,830,975	2.00
3.00	Total (sum of lines 1-2)	0	0	0	19,606,001	4,830,975	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	4,387,371	367,947	0	0	13,229,883	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	15,962,411	2.00
3.00	Total (sum of lines 1-2)	4,387,371	367,947	0	0	29,192,294	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0169

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

Worksheet A-8

Date/Time Prepared:
5/29/2019 3:05 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 - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B		0	ADMINISTRATIVE & GENERAL	5.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-26,173		ADMINISTRATIVE & GENERAL	5.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00		0	7.00
8.00 Television and radio service (chapter 21)			0		0.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-519,470					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	2,344,403					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-2,372,374		CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts			0		0.00		0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	UTILIZATION REVIEW-SNF	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 MISC REVENUE			0		0.00		0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0169

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

Worksheet A-8

Date/Time Prepared:
5/29/2019 3:05 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
33.01	Misc Revenue	B	-137,153	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.01
33.02	Misc Revenue	B	-1,260	ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03	Misc Revenue	B	-26,257	OPERATION OF PLANT	7.00	0 33.03
33.04	Misc Revenue	B	-24,144	DIETARY	10.00	0 33.04
33.05	Misc Revenue	B	-134,242	NURSING ADMINISTRATION	13.00	0 33.05
33.06	Misc Revenue	B	-48,550	PHARMACY	15.00	0 33.06
33.07	Misc Revenue	B	-45	ADULTS & PEDIATRICS	30.00	0 33.07
33.08	Misc Revenue	B	-3,433	NEONATAL INTENSIVE CARE UNIT	35.00	0 33.08
33.09	Misc Revenue	B	-2,500	OPERATING ROOM	50.00	0 33.09
33.10	Misc Revenue	B	-105,098	RADIOLOGY-DIAGNOSTIC	54.00	0 33.10
33.11	Misc Revenue	B	-116,800	MRI	58.00	0 33.11
33.12	Misc Revenue	B	-1,193,952	LABORATORY	60.00	0 33.12
33.13	Misc Revenue	B	-820	PHYSICAL THERAPY	66.00	0 33.13
33.14	Misc Revenue	B	-20	ELECTROENCEPHALOGRAPHY	70.00	0 33.14
33.15	Misc Revenue	B	-32,879	EMERGENCY	91.00	0 33.15
34.00	HAF Tax Offset	A	-23,138,735	ADMINISTRATIVE & GENERAL	5.00	0 34.00
34.01	00 Non-Allow Interest Expense	A	-3,434,565	CAP REL COSTS-BLDG & FIXT	1.00	11 34.01
34.02	LOC Non-Allow Interest Expense	A	-64,625	CAP REL COSTS-BLDG & FIXT	1.00	11 34.02
34.03	12A Non-Allow Interest Expense	A	-1,675,048	CAP REL COSTS-BLDG & FIXT	1.00	11 34.03
34.04	12B Non-Allow Interest Expense	A	-211,837	CAP REL COSTS-BLDG & FIXT	1.00	11 34.04
34.05	50M BMO Non-Allow Interest Expense	A	-123,905	CAP REL COSTS-BLDG & FIXT	1.00	11 34.05
34.06	16AB Non-Allow Interest Expense	A	-882,514	CAP REL COSTS-BLDG & FIXT	1.00	11 34.06
34.07	Non-Allow Debt Issuance Expense	A	74,866	ADMINISTRATIVE & GENERAL	5.00	0 34.07
34.08	Loss on Assets	A	-1,226	ADMINISTRATIVE & GENERAL	5.00	0 34.08
36.00	Meals of Wheels Cost	A	-51,025	CAFETERIA	11.00	0 36.00
36.01	Sponsorship	A	-75,500	ADMINISTRATIVE & GENERAL	5.00	0 36.01
36.02	Nurse Practitioner Offset	A	-293,970	NEONATAL INTENSIVE CARE UNIT	35.00	0 36.02
36.03	CARDIAC CATH SHARED SERVICES	A	127,131	CARDIAC CATHETERIZATION	59.00	0 36.03
36.04	CARDIAC MONITORING SHARED SERVICES	A	-294,258	ELECTROCARDIOLOGY	69.00	0 36.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-32,445,978			50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0169

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

Worksheet A-8-1

Date/Time Prepared: 5/29/2019 3:05 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	21.00	I&R SERVICES-SALARY & FRINGE	INTERNS & RESIDENTS	406,401	0	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM COST	INTERNS & RESIDENTS	621,282	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	7250 CLEARVISTA	238,275	192,934	3.00
3.01	70.00	ELECTROENCEPHALOGRAPHY	7250 CLEARVISTA	122,126	96,906	3.01
3.02	15.00	PHARMACY	7250 CLEARVISTA	4,465	3,543	3.02
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	5,728,817	0	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	5,357,120	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	53,376,651	75,243,279	4.02
4.03	7.00	OPERATION OF PLANT	HOME OFFICE	580,400	0	4.03
4.04	13.00	NURSING ADMINISTRATION	HOME OFFICE	4,683,676	0	4.04
4.05	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	1,330,339	0	4.05
4.06	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	2,667,433	0	4.06
4.07	30.00	ADULTS & PEDIATRICS	HOME OFFICE	797,906	0	4.07
4.08	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	105,223	0	4.08
4.09	69.00	ELECTROCARDIOLOGY	HOME OFFICE	49,036	0	4.09
4.10	70.00	ELECTROENCEPHALOGRAPHY	HOME OFFICE	336,711	0	4.10
4.11	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	454,036	0	4.11
4.12	30.00	ADULTS & PEDIATRICS	HOME OFFICE	36,404	0	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR AND CAL	984,764	0	4.13
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			77,881,065	75,536,662	5.00

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

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

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

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

6.00	B	CHNW	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0169

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2019 3:05 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	406,401	0		1.00
2.00	621,282	0		2.00
3.00	45,341	0		3.00
3.01	25,220	0		3.01
3.02	922	0		3.02
4.00	5,728,817	9		4.00
4.01	5,357,120	0		4.01
4.02	-21,866,628	0		4.02
4.03	580,400	0		4.03
4.04	4,683,676	0		4.04
4.05	1,330,339	0		4.05
4.06	2,667,433	0		4.06
4.07	797,906	0		4.07
4.08	105,223	0		4.08
4.09	49,036	0		4.09
4.10	336,711	0		4.10
4.11	454,036	0		4.11
4.12	36,404	0		4.12
4.13	984,764	0		4.13
5.00	2,344,403			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0169

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2019 3:05 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	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	529,753	138,507	391,246	211,500	1,773	1.00
2.00	35.00	AGGREGATE-NEONATAL INTENSIVE CARE UN	170,000	170,000	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			699,753	308,507	391,246		1,773	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	180,283	9,014	0	0	0	1.00
2.00	35.00	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			180,283	9,014	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	180,283	210,963	349,470	1.00
2.00	35.00	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	0	0	170,000	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	180,283	210,963	519,470	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2019 3:05 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	13,229,883	13,229,883			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	15,962,411		15,962,411		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,528,173	27,080	7,976,834	13,532,087	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	63,465,869	402,992	3,231,753	753,344	5.00
7.00 00700	OPERATION OF PLANT	10,863,495	1,763,950	10,572	410,593	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	876,929	46,798	40	0	8.00
9.00 00900	HOUSEKEEPING	4,815,889	107,671	3,912	392,589	9.00
10.00 01000	DIETARY	1,562,615	115,971	4,390	86,363	10.00
11.00 01100	CAFETERIA	1,271,275	319,953	12,809	241,218	11.00
13.00 01300	NURSING ADMINISTRATION	7,094,423	18,857	1,706	275,264	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	710,045	301,422	871,713	0	14.00
15.00 01500	PHARMACY	4,883,962	146,264	292,558	627,224	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,109,625	18,321	40	51,899	16.00
17.00 01700	SOCIAL SERVICE	1,830,448	21,381	18	193,946	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	406,401	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	621,282	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	38,224,811	4,082,816	325,748	3,586,281	30.00
31.00 03100	INTENSIVE CARE UNIT	5,786,886	884,031	92,410	585,541	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	8,467,235	797,550	84,370	902,014	35.00
40.00 04000	SUBPROVIDER - IPF	2,121,792	139,781	8,671	218,264	40.00
43.00 04300	NURSERY	2,407,581	379,756	23,978	230,624	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	9,707,530	602,059	756,344	657,511	50.00
51.00 05100	RECOVERY ROOM	3,229,851	332,212	4,091	322,048	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	6,546,963	945,574	59,704	646,642	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,245,932	198,627	209,886	426,567	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	797,246	201,725	202,064	70,466	55.00
57.00 05700	CT SCAN	1,392,380	26,679	128,277	140,350	57.00
58.00 05800	MRI	865,714	111,725	132,288	70,885	58.00
59.00 05900	CARDIAC CATHETERIZATION	127,176	0	628	0	59.00
60.00 06000	LABORATORY	9,410,944	115,799	5,436	3,441	60.00
64.00 06400	INTRAVENOUS THERAPY	384,652	157,663	1,517	39,594	64.00
65.00 06500	RESPIRATORY THERAPY	3,807,303	125,246	119,692	369,976	65.00
66.00 06600	PHYSICAL THERAPY	5,636,256	0	433,210	593,189	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,687,272	0	18,207	158,737	67.00
68.00 06800	SPEECH PATHOLOGY	320,023	0	3,453	30,107	68.00
69.00 06900	ELECTROCARDIOLOGY	613,863	0	4,885	3,740	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,773,180	30,695	106,781	128,314	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,073,633	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	12,842,066	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	14,729,369	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	1,182,740	2,391	0	0	74.00
76.00 03330	ENDOSCOPY	1,848,558	161,545	198,336	153,327	76.00
76.06 03954	IMAGING CENTER	2,606,910	0	416,845	187,985	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	7,762,650	0	127,503	0	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.26 04975	SPINE CENTER	247,630	0	241	25,213	90.26
91.00 09100	EMERGENCY	9,420,735	554,171	63,000	876,635	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	313,501,606	13,140,705	15,933,910	13,459,891	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	76,728	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	116,952	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00
194.06 07956	PAVILIONS	72,804	0	0	0	194.06
194.08 07958	OTHER NRCC	1,639,686	12,450	28,501	72,196	194.08
194.10 07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	194.10
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	315,331,048	13,229,883	15,962,411	13,532,087	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2019 3:05 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	67,853,958					5.00
7.00	00700	OPERATION OF PLANT	3,577,707	16,626,317				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	253,281	70,504	1,247,552			8.00
9.00	00900	HOUSEKEEPING	1,458,670	162,214	623,776	7,564,721		9.00
10.00	01000	DIETARY	485,123	174,719	0	80,623	2,509,804	10.00
11.00	01100	CAFETERIA	505,938	482,032	0	222,431	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,026,281	28,409	0	13,109	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	516,336	454,113	0	209,548	0	14.00
15.00	01500	PHARMACY	1,631,391	220,358	0	101,683	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	871,870	27,602	0	12,737	0	16.00
17.00	01700	SOCIAL SERVICE	560,922	32,212	0	14,864	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	111,428	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	170,345	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,672,588	6,151,058	232,762	2,838,365	1,650,318	30.00
31.00	03100	INTENSIVE CARE UNIT	2,014,935	1,331,856	0	614,576	172,730	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,810,696	1,201,566	42,371	554,455	357,490	35.00
40.00	04000	SUBPROVIDER - I PF	682,307	210,590	12,862	97,176	107,953	40.00
43.00	04300	NURSERY	834,048	572,129	32,979	264,005	221,313	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,214,369	907,045	0	418,550	0	50.00
51.00	05100	RECOVERY ROOM	1,066,079	500,501	0	230,953	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,247,994	1,424,575	82,114	657,361	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,393,127	299,246	0	138,085	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	348,624	303,914	9,778	140,239	0	55.00
57.00	05700	CT SCAN	462,735	40,193	0	18,547	0	57.00
58.00	05800	MRI	323,704	168,322	0	77,671	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	35,042	0	0	0	0	59.00
60.00	06000	LABORATORY	2,614,505	174,459	0	80,503	0	60.00
64.00	06400	INTRAVENOUS THERAPY	159,965	237,530	0	109,607	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,212,497	188,693	0	87,071	0	65.00
66.00	06600	PHYSICAL THERAPY	1,826,787	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	511,136	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	96,946	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	170,676	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	559,051	46,244	0	21,339	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,229,666	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,521,076	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,038,543	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	324,943	3,602	0	1,662	0	74.00
76.00	03330	ENDOSCOPY	647,556	243,379	0	112,306	0	76.00
76.06	03954	MAGING CENTER	880,605	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	2,163,346	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.26	04975	SPI NE CENTER	74,875	0	0	0	0	90.26
91.00	09100	EMERGENCY	2,992,582	834,899	210,910	385,259	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,300,295	16,491,964	1,247,552	7,502,725	2,509,804	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,038	115,596	0	53,341	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,066	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	PAVILLIONS	19,962	0	0	0	0	194.06
194.08	07958	OTHER NRCC	480,597	18,757	0	8,655	0	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
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)	67,853,958	16,626,317	1,247,552	7,564,721	2,509,804	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2019 3:05 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	3,055,656					11.00
13.00	01300	78,838	9,536,887				13.00
14.00	01400	0	4,768,443	7,831,620			14.00
15.00	01500	144,083	0	3,915,789	11,963,312		15.00
16.00	01600	13,593	0	23	5,981,654	10,087,364	16.00
17.00	01700	54,371	0	155	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,062,954	2,296,135	203,424	0	1,218,658	30.00
31.00	03100	165,832	358,221	33,708	0	163,584	31.00
35.00	02060	233,796	505,032	24,638	0	628,884	35.00
40.00	04000	59,808	129,194	5,246	0	55,664	40.00
43.00	04300	67,964	146,812	12,209	0	68,064	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	193,017	416,945	200,942	0	1,302,910	50.00
51.00	05100	84,275	0	28,859	0	248,856	51.00
52.00	05200	165,832	358,221	30,399	0	158,218	52.00
54.00	05400	114,179	0	13,632	0	285,499	54.00
55.00	05500	19,030	0	13,773	0	217,885	55.00
57.00	05700	38,060	0	1,002	0	523,012	57.00
58.00	05800	19,030	0	241	0	138,620	58.00
59.00	05900	0	0	4	0	17,549	59.00
60.00	06000	0	0	151,234	0	894,116	60.00
64.00	06400	10,874	0	805	0	7,433	64.00
65.00	06500	100,587	0	21,349	0	205,966	65.00
66.00	06600	38,060	0	12,284	0	197,845	66.00
67.00	06700	38,060	0	3,240	0	55,923	67.00
68.00	06800	8,156	0	615	0	16,211	68.00
69.00	06900	2,719	0	66	0	74,034	69.00
70.00	07000	40,778	0	10,606	0	88,311	70.00
71.00	07100	0	0	1,803,717	0	568,591	71.00
72.00	07200	0	0	1,214,423	0	322,297	72.00
73.00	07300	0	0	0	5,981,658	770,808	73.00
74.00	07400	0	0	177	0	23,959	74.00
76.00	03330	43,497	0	20,454	0	166,135	76.00
76.06	03954	0	0	11,091	0	366,719	76.06
76.07	03955	0	0	426	0	138,991	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.26	04975	0	0	570	0	4,232	90.26
91.00	09100	258,263	557,884	90,999	0	1,158,390	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		3,055,656	9,536,887	7,826,100	11,963,312	10,087,364	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	4,119	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.06	07956	0	0	486	0	0	194.06
194.08	07958	0	0	915	0	0	194.08
194.10	07960	0	0	0	0	0	194.10
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		3,055,656	9,536,887	7,831,620	11,963,312	10,087,364	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2019 3:05 pm

Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		Subtotal	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
			17.00	19.00		
GENERAL SERVICE COST CENTERS						
1.00 00100						1.00
2.00 00200						2.00
4.00 00400						4.00
5.00 00500						5.00
7.00 00700						7.00
8.00 00800						8.00
9.00 00900						9.00
10.00 01000						10.00
11.00 01100						11.00
13.00 01300						13.00
14.00 01400						14.00
15.00 01500						15.00
16.00 01600						16.00
17.00 01700	2,708,317					17.00
19.00 01900		0				19.00
21.00 02100			517,829			21.00
22.00 02200				791,627		22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	1,780,850	0	338,600	517,632	77,183,000	30.00
31.00 03100	186,392	0	0	0	12,390,702	31.00
35.00 02060	385,766	0	0	0	16,995,863	35.00
40.00 04000	116,491	0	138,699	212,035	4,316,533	40.00
43.00 04300	238,818	0	0	0	5,500,280	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	0	0	0	0	18,377,222	50.00
51.00 05100	0	0	0	0	6,047,725	51.00
52.00 05200	0	0	0	0	13,323,597	52.00
54.00 05400	0	0	0	0	7,324,780	54.00
55.00 05500	0	0	0	0	2,324,744	55.00
57.00 05700	0	0	0	0	2,771,235	57.00
58.00 05800	0	0	0	0	1,908,200	58.00
59.00 05900	0	0	0	0	180,399	59.00
60.00 06000	0	0	0	0	13,450,437	60.00
64.00 06400	0	0	0	0	1,109,640	64.00
65.00 06500	0	0	0	0	6,238,380	65.00
66.00 06600	0	0	0	0	8,737,631	66.00
67.00 06700	0	0	0	0	2,472,575	67.00
68.00 06800	0	0	0	0	475,511	68.00
69.00 06900	0	0	0	0	869,983	69.00
70.00 07000	0	0	0	0	2,805,299	70.00
71.00 07100	0	0	0	0	26,675,607	71.00
72.00 07200	0	0	0	0	17,899,862	72.00
73.00 07300	0	0	0	0	25,520,378	73.00
74.00 07400	0	0	0	0	1,539,474	74.00
76.00 03330	0	0	0	0	3,595,093	76.00
76.06 03954	0	0	0	0	4,470,155	76.06
76.07 03955	0	0	0	0	10,192,916	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	0	0	0	0	0	90.00
90.26 04975	0	0	0	0	352,761	90.26
91.00 09100	0	0	40,530	61,960	17,506,217	91.00
92.00 09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300						113.00
114.00 11400						114.00
118.00 11800	2,708,317	0	517,829	791,627	312,556,199	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	0	0	0	0	266,703	190.00
191.00 19100	0	0	0	0	0	191.00
192.00 19200	0	0	0	0	153,137	192.00
193.00 19300	0	0	0	0	0	193.00
194.00 07950	0	0	0	0	0	194.00
194.06 07956	0	0	0	0	93,252	194.06
194.08 07958	0	0	0	0	2,261,757	194.08
194.10 07960	0	0	0	0	0	194.10
200.00						200.00
201.00						201.00
202.00	2,708,317	0	517,829	791,627	315,331,048	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2019 3:05 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-856,232	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	35.00
40.00	04000	SUBPROVIDER - I PF	-350,734	40.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
76.00	03330	ENDOSCOPY	0	76.00
76.06	03954	IMAGING CENTER	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	76.07
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.26	04975	SPINE CENTER	0	90.26
91.00	09100	EMERGENCY	-102,490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,309,456	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	HOME OFFICE	0	194.00
194.06	07956	PAVILLIONS	0	194.06
194.08	07958	OTHER NRCC	0	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	194.10
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	-1,309,456	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2019 3:05 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	27,080	7,976,834	8,003,914	8,003,914 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	402,992	3,231,753	3,634,745	445,586 5.00
7.00 00700	OPERATION OF PLANT	0	1,763,950	10,572	1,774,522	242,857 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	46,798	40	46,838	0 8.00
9.00 00900	HOUSEKEEPING	0	107,671	3,912	111,583	232,208 9.00
10.00 01000	DIETARY	0	115,971	4,390	120,361	51,082 10.00
11.00 01100	CAFETERIA	0	319,953	12,809	332,762	142,675 11.00
13.00 01300	NURSING ADMINISTRATION	0	18,857	1,706	20,563	162,812 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	301,422	871,713	1,173,135	0 14.00
15.00 01500	PHARMACY	0	146,264	292,558	438,822	370,989 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	18,321	40	18,361	30,697 16.00
17.00 01700	SOCIAL SERVICE	0	21,381	18	21,399	114,715 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	4,082,816	325,748	4,408,564	2,121,190 30.00
31.00 03100	INTENSIVE CARE UNIT	0	884,031	92,410	976,441	346,334 31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	797,550	84,370	881,920	533,522 35.00
40.00 04000	SUBPROVIDER - I PF	0	139,781	8,671	148,452	129,098 40.00
43.00 04300	NURSERY	0	379,756	23,978	403,734	136,409 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	602,059	756,344	1,358,403	388,903 50.00
51.00 05100	RECOVERY ROOM	0	332,212	4,091	336,303	190,484 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	945,574	59,704	1,005,278	382,474 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	198,627	209,886	408,513	252,305 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	201,725	202,064	403,789	41,679 55.00
57.00 05700	CT SCAN	0	26,679	128,277	154,956	83,014 57.00
58.00 05800	MRI	0	111,725	132,288	244,013	41,927 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	628	628	0 59.00
60.00 06000	LABORATORY	0	115,799	5,436	121,235	2,035 60.00
64.00 06400	INTRAVENOUS THERAPY	0	157,663	1,517	159,180	23,419 64.00
65.00 06500	RESPIRATORY THERAPY	0	125,246	119,692	244,938	218,833 65.00
66.00 06600	PHYSICAL THERAPY	0	0	433,210	433,210	350,858 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	18,207	18,207	93,890 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	3,453	3,453	17,808 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	4,885	4,885	2,212 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	30,695	106,781	137,476	75,895 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	2,391	0	2,391	0 74.00
76.00 03330	ENDOSCOPY	0	161,545	198,336	359,881	90,690 76.00
76.06 03954	IMAGING CENTER	0	0	416,845	416,845	111,189 76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	0	127,503	127,503	0 76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.26 04975	SPINE CENTER	0	0	241	241	14,913 90.26
91.00 09100	EMERGENCY	0	554,171	63,000	617,171	518,510 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	13,140,705	15,933,910	29,074,615	7,961,212 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	76,728	0	76,728	0 190.00
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	HOME OFFICE	0	0	0	0	0 194.00
194.06 07956	PAVILLIONS	0	0	0	0	0 194.06
194.08 07958	OTHER NRCC	0	12,450	28,501	40,951	42,702 194.08
194.10 07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0 194.10
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118 through 201)	0	13,229,883	15,962,411	29,192,294	8,003,914 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/29/2019 3:05 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	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,080,331				5.00
7.00	00700	OPERATION OF PLANT	215,145	2,232,524			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,231	9,467	71,536		8.00
9.00	00900	HOUSEKEEPING	87,717	21,782	35,766	489,056	9.00
10.00	01000	DIETARY	29,173	23,461	0	5,212	229,289
11.00	01100	CAFETERIA	30,425	64,726	0	14,380	0
13.00	01300	NURSING ADMINISTRATION	121,850	3,815	0	848	0
14.00	01400	CENTRAL SERVICES & SUPPLY	31,050	60,977	0	13,547	0
15.00	01500	PHARMACY	98,104	29,589	0	6,574	0
16.00	01600	MEDICAL RECORDS & LIBRARY	52,430	3,706	0	823	0
17.00	01700	SOCIAL SERVICE	33,731	4,325	0	961	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	6,701	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	10,244	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	761,996	825,941	13,347	183,501	150,769
31.00	03100	INTENSIVE CARE UNIT	121,168	178,837	0	39,732	15,780
35.00	02060	NEONATAL INTENSIVE CARE UNIT	169,021	161,342	2,430	35,845	32,659
40.00	04000	SUBPROVIDER - I PF	41,031	28,277	738	6,282	9,862
43.00	04300	NURSERY	50,155	76,823	1,891	17,068	20,219
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	193,296	121,795	0	27,059	0
51.00	05100	RECOVERY ROOM	64,109	67,206	0	14,931	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	135,183	191,287	4,709	42,498	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	83,776	40,182	0	8,927	0
55.00	05500	RADIOLOGY-THERAPEUTIC	20,965	40,808	561	9,066	0
57.00	05700	CT SCAN	27,827	5,397	0	1,199	0
58.00	05800	MRI	19,466	22,602	0	5,021	0
59.00	05900	CARDIAC CATHETERIZATION	2,107	0	0	0	0
60.00	06000	LABORATORY	157,223	23,426	0	5,204	0
64.00	06400	INTRAVENOUS THERAPY	9,620	31,895	0	7,086	0
65.00	06500	RESPIRATORY THERAPY	72,914	25,337	0	5,629	0
66.00	06600	PHYSICAL THERAPY	109,854	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	30,737	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	5,830	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	10,264	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	33,619	6,209	0	1,380	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	314,486	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	211,740	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	242,858	0	0	0	0
74.00	07400	RENAL DIALYSIS	19,540	484	0	107	0
76.00	03330	ENDOSCOPY	38,941	32,680	0	7,261	0
76.06	03954	IMAGING CENTER	52,955	0	0	0	0
76.07	03955	BREAST DIAGNOSTIC CENTER	130,093	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.26	04975	SPI NE CENTER	4,503	0	0	0	0
91.00	09100	EMERGENCY	179,959	112,107	12,094	24,907	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,047,037	2,214,483	71,536	485,048	229,289
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,265	15,522	0	3,448	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,928	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0	0
194.06	07956	PAVILLIONS	1,200	0	0	0	0
194.08	07958	OTHER NRCC	28,901	2,519	0	560	0
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	4,080,331	2,232,524	71,536	489,056	229,289

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0169		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part II Date/Time Prepared: 5/29/2019 3:05 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	584,968					11.00
13.00	01300	15,093	324,981				13.00
14.00	01400	0	162,489	1,441,198			14.00
15.00	01500	27,583	0	720,610	1,692,271		15.00
16.00	01600	2,602	0	4	846,138	954,761	16.00
17.00	01700	10,409	0	28	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	203,491	78,244	37,434	0	115,307	30.00
31.00	03100	31,746	12,207	6,203	0	15,478	31.00
35.00	02060	44,757	17,210	4,534	0	59,504	35.00
40.00	04000	11,450	4,402	965	0	5,267	40.00
43.00	04300	13,011	5,003	2,247	0	6,440	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	36,951	14,208	36,977	0	123,595	50.00
51.00	05100	16,133	0	5,311	0	23,546	51.00
52.00	05200	31,746	12,207	5,594	0	14,970	52.00
54.00	05400	21,858	0	2,508	0	27,013	54.00
55.00	05500	3,643	0	2,535	0	20,616	55.00
57.00	05700	7,286	0	184	0	49,486	57.00
58.00	05800	3,643	0	44	0	13,116	58.00
59.00	05900	0	0	1	0	1,660	59.00
60.00	06000	0	0	27,830	0	84,600	60.00
64.00	06400	2,082	0	148	0	703	64.00
65.00	06500	19,256	0	3,929	0	19,488	65.00
66.00	06600	7,286	0	2,260	0	18,720	66.00
67.00	06700	7,286	0	596	0	5,291	67.00
68.00	06800	1,561	0	113	0	1,534	68.00
69.00	06900	520	0	12	0	7,005	69.00
70.00	07000	7,807	0	1,952	0	8,356	70.00
71.00	07100	0	0	331,919	0	53,799	71.00
72.00	07200	0	0	223,478	0	30,495	72.00
73.00	07300	0	0	0	846,133	72,932	73.00
74.00	07400	0	0	33	0	2,267	74.00
76.00	03330	8,327	0	3,764	0	15,719	76.00
76.06	03954	0	0	2,041	0	34,698	76.06
76.07	03955	0	0	78	0	13,151	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.26	04975	0	0	105	0	400	90.26
91.00	09100	49,441	19,011	16,746	0	109,605	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		584,968	324,981	1,440,183	1,692,271	954,761	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	758	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.06	07956	0	0	89	0	0	194.06
194.08	07958	0	0	168	0	0	194.08
194.10	07960	0	0	0	0	0	194.10
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		584,968	324,981	1,441,198	1,692,271	954,761	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		Subtotal	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
			17.00	19.00		21.00
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE	185,568				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0		6,701		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			10,244	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	122,020			9,021,804	30.00
31.00 03100	INTENSIVE CARE UNIT	12,771			1,756,697	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	26,432			1,969,176	35.00
40.00 04000	SUBPROVIDER - I/PF	7,982			393,806	40.00
43.00 04300	NURSERY	16,363			749,363	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0			2,301,187	50.00
51.00 05100	RECOVERY ROOM	0			718,023	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0			1,825,946	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0			845,082	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0			543,662	55.00
57.00 05700	CT SCAN	0			329,349	57.00
58.00 05800	MRI	0			349,832	58.00
59.00 05900	CARDIAC CATHETERIZATION	0			4,396	59.00
60.00 06000	LABORATORY	0			421,553	60.00
64.00 06400	INTRAVENOUS THERAPY	0			234,133	64.00
65.00 06500	RESPIRATORY THERAPY	0			610,324	65.00
66.00 06600	PHYSICAL THERAPY	0			922,188	66.00
67.00 06700	OCCUPATIONAL THERAPY	0			156,007	67.00
68.00 06800	SPEECH PATHOLOGY	0			30,299	68.00
69.00 06900	ELECTROCARDIOLOGY	0			24,898	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0			272,694	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0			700,204	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0			465,713	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0			1,161,923	73.00
74.00 07400	RENAL DIALYSIS	0			24,822	74.00
76.00 03330	ENDOSCOPY	0			557,263	76.00
76.06 03954	IMAGING CENTER	0			617,728	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0			270,825	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0			0	90.00
90.26 04975	SPINE CENTER	0			20,162	90.26
91.00 09100	EMERGENCY	0			1,659,551	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	185,568	0	0	0	28,958,610
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			96,963	190.00
191.00 19100	RESEARCH	0			0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0			2,686	192.00
193.00 19300	NONPAID WORKERS	0			0	193.00
194.00 07950	HOME OFFICE	0			0	194.00
194.06 07956	PAVILLIONS	0			1,289	194.06
194.08 07958	OTHER NRCC	0			115,801	194.08
194.10 07960	COMMUNITY REHAB HOSPITAL	0			0	194.10
200.00	Cross Foot Adjustments		0	6,701	10,244	16,945
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	185,568	0	6,701	10,244	29,192,294

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00	
5.00	00500	ADMINISTRATIVE & GENERAL		5.00	
7.00	00700	OPERATION OF PLANT		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE		8.00	
9.00	00900	HOUSEKEEPING		9.00	
10.00	01000	DIETARY		10.00	
11.00	01100	CAFETERIA		11.00	
13.00	01300	NURSING ADMINISTRATION		13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00	
15.00	01500	PHARMACY		15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00	
17.00	01700	SOCIAL SERVICE		17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	9,021,804	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,756,697	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	1,969,176	35.00
40.00	04000	SUBPROVIDER - I PF	0	393,806	40.00
43.00	04300	NURSERY	0	749,363	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,301,187	50.00
51.00	05100	RECOVERY ROOM	0	718,023	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,825,946	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	845,082	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	543,662	55.00
57.00	05700	CT SCAN	0	329,349	57.00
58.00	05800	MRI	0	349,832	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,396	59.00
60.00	06000	LABORATORY	0	421,553	60.00
64.00	06400	INTRAVENOUS THERAPY	0	234,133	64.00
65.00	06500	RESPIRATORY THERAPY	0	610,324	65.00
66.00	06600	PHYSICAL THERAPY	0	922,188	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	156,007	67.00
68.00	06800	SPEECH PATHOLOGY	0	30,299	68.00
69.00	06900	ELECTROCARDIOLOGY	0	24,898	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	272,694	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	700,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	465,713	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,161,923	73.00
74.00	07400	RENAL DIALYSIS	0	24,822	74.00
76.00	03330	ENDOSCOPY	0	557,263	76.00
76.06	03954	IMAGING CENTER	0	617,728	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	270,825	76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.26	04975	SPINE CENTER	0	20,162	90.26
91.00	09100	EMERGENCY	0	1,659,551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	28,958,610	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	96,963	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,686	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HOME OFFICE	0	0	194.00
194.06	07956	PAVILLIONS	0	1,289	194.06
194.08	07958	OTHER NRCC	0	115,801	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	194.10
200.00		Cross Foot Adjustments	0	16,945	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	29,192,294	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	691,776				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		31,736,808			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,416	15,859,711	99,568,893		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	21,072	6,425,442	5,543,084	-67,853,958	5.00
7.00 00700	OPERATION OF PLANT	92,235	21,019	3,021,133	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,447	80	0	0	8.00
9.00 00900	HOUSEKEEPING	5,630	7,777	2,888,661	0	9.00
10.00 01000	DIETARY	6,064	8,729	635,458	0	10.00
11.00 01100	CAFETERIA	16,730	25,467	1,774,879	0	11.00
13.00 01300	NURSING ADMINISTRATION	986	3,391	2,025,382	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	15,761	1,733,159	0	0	14.00
15.00 01500	PHARMACY	7,648	581,671	4,615,095	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	958	80	381,875	0	16.00
17.00 01700	SOCIAL SERVICE	1,118	36	1,427,048	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	213,486	647,659	26,387,915	0	30.00
31.00 03100	INTENSIVE CARE UNIT	46,225	183,732	4,308,392	0	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	41,703	167,746	6,636,997	0	35.00
40.00 04000	SUBPROVIDER - IPF	7,309	17,240	1,605,978	0	40.00
43.00 04300	NURSERY	19,857	47,673	1,696,926	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	31,481	1,503,779	4,837,949	0	50.00
51.00 05100	RECOVERY ROOM	17,371	8,134	2,369,622	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	49,443	118,704	4,757,972	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	10,386	417,300	3,138,670	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	10,548	401,749	518,489	0	55.00
57.00 05700	CT SCAN	1,395	255,043	1,032,691	0	57.00
58.00 05800	MRI	5,842	263,018	521,573	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	1,248	0	0	59.00
60.00 06000	LABORATORY	6,055	10,808	25,321	0	60.00
64.00 06400	INTRAVENOUS THERAPY	8,244	3,016	291,332	0	64.00
65.00 06500	RESPIRATORY THERAPY	6,549	237,974	2,722,272	0	65.00
66.00 06600	PHYSICAL THERAPY	0	861,317	4,364,665	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	36,200	1,167,985	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	6,866	221,530	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	9,712	27,517	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,605	212,304	944,130	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	125	0	0	0	74.00
76.00 03330	ENDOSCOPY	8,447	394,336	1,128,178	0	76.00
76.06 03954	IMAGING CENTER	0	828,781	1,383,191	0	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	253,504	0	0	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.26 04975	SPINE CENTER	0	479	185,515	0	90.26
91.00 09100	EMERGENCY	28,977	125,257	6,450,254	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	687,113	31,680,141	99,037,679	-67,853,958	245,457,773
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,012	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00
194.06 07956	PAVILLIONS	0	0	0	0	194.06
194.08 07958	OTHER NRCC	651	56,667	531,214	0	194.08
194.10 07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	194.10
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1
Date/Time Prepared:
5/29/2019 3:05 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
202.00	Cost to be allocated (per Wkst. B, Part I)	13,229,883	15,962,411	13,532,087	5A	67,853,958	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	19.124519	0.502962	0.135907		0.274183	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			8,003,914		4,080,331	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.080386		0.016488	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: 15-0169

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

Worksheet B-1

Date/Time Prepared:
5/29/2019 3:05 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	577,053				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,447	71,194			8.00
9.00	00900	HOUSEKEEPING	5,630	35,597	568,976		9.00
10.00	01000	DIETARY	6,064	0	6,064	86,789	10.00
11.00	01100	CAFETERIA	16,730	0	16,730	0	11.00
13.00	01300	NURSING ADMINISTRATION	986	0	986	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,761	0	15,761	0	14.00
15.00	01500	PHARMACY	7,648	0	7,648	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	958	0	958	0	16.00
17.00	01700	SOCIAL SERVICE	1,118	0	1,118	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	213,486	13,283	213,486	57,068	30.00
31.00	03100	INTENSIVE CARE UNIT	46,225	0	46,225	5,973	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	41,703	2,418	41,703	12,362	35.00
40.00	04000	SUBPROVIDER - IPF	7,309	734	7,309	3,733	40.00
43.00	04300	NURSERY	19,857	1,882	19,857	7,653	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	31,481	0	31,481	0	50.00
51.00	05100	RECOVERY ROOM	17,371	0	17,371	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	49,443	4,686	49,443	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,386	0	10,386	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	10,548	558	10,548	0	55.00
57.00	05700	CT SCAN	1,395	0	1,395	0	57.00
58.00	05800	MRI	5,842	0	5,842	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	6,055	0	6,055	0	60.00
64.00	06400	INTRAVENOUS THERAPY	8,244	0	8,244	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,549	0	6,549	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,605	0	1,605	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	125	0	125	0	74.00
76.00	03330	ENDOSCOPY	8,447	0	8,447	0	76.00
76.06	03954	IMAGING CENTER	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.26	04975	SPINE CENTER	0	0	0	0	90.26
91.00	09100	EMERGENCY	28,977	12,036	28,977	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	572,390	71,194	564,313	86,789	1,124
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,012	0	4,012	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	194.00
194.06	07956	PAVILLIONS	0	0	0	0	194.06
194.08	07958	OTHER NRCC	651	0	651	0	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	194.10
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)	16,626,317	1,247,552	7,564,721	2,509,804	3,055,656
203.00		Unit cost multiplier (Wkst. B, Part I)	28.812461	17.523274	13.295325	28.918457	2,718.555160

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1

Date/Time Prepared:
5/29/2019 3:05 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	2,232,524	71,536	489,056	229,289	584,968	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.868837	1.004804	0.859537	2.641913	520.434164	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: 15-0169

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

Worksheet B-1

Date/Time Prepared:
5/29/2019 3:05 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	1,624					13.00
14.00	01400	812	82,816,871				14.00
15.00	01500	0	41,408,437	28,793,270			15.00
16.00	01600	0	241	14,396,635	1,459,473,247		16.00
17.00	01700	0	1,636		0	86,789	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	391	2,151,128	0	176,310,491	57,068	30.00
31.00	03100	61	356,450	0	23,666,719	5,973	31.00
35.00	02060	86	260,538	0	90,984,335	12,362	35.00
40.00	04000	22	55,472	0	8,053,217	3,733	40.00
43.00	04300	25	129,103	0	9,847,218	7,653	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	71	2,124,887	0	188,573,743	0	50.00
51.00	05100	0	305,174	0	36,003,536	0	51.00
52.00	05200	61	321,462	0	22,890,363	0	52.00
54.00	05400	0	144,150	0	41,304,857	0	54.00
55.00	05500	0	145,647	0	31,522,658	0	55.00
57.00	05700	0	10,598	0	75,667,221	0	57.00
58.00	05800	0	2,549	0	20,055,048	0	58.00
59.00	05900	0	45	0	2,538,853	0	59.00
60.00	06000	0	1,599,248	0	129,357,058	0	60.00
64.00	06400	0	8,510	0	1,075,444	0	64.00
65.00	06500	0	225,762	0	29,798,389	0	65.00
66.00	06600	0	129,896	0	28,623,451	0	66.00
67.00	06700	0	34,267	0	8,090,743	0	67.00
68.00	06800	0	6,499	0	2,345,397	0	68.00
69.00	06900	0	698	0	10,710,977	0	69.00
70.00	07000	0	112,151	0	12,776,486	0	70.00
71.00	07100	0	19,073,636	0	82,261,468	0	71.00
72.00	07200	0	12,842,066	0	46,628,663	0	72.00
73.00	07300	0	0	14,396,635	111,517,290	0	73.00
74.00	07400	0	1,868	0	3,466,226	0	74.00
76.00	03330	0	216,289	0	24,035,729	0	76.00
76.06	03954	0	117,278	0	53,055,440	0	76.06
76.07	03955	0	4,506	0	20,108,703	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.26	04975	0	6,029	0	612,326	0	90.26
91.00	09100	95	962,285	0	167,591,198	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		1,624	82,758,505	28,793,270	1,459,473,247	86,789	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	43,552	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.06	07956	0	5,138	0	0	0	194.06
194.08	07958	0	9,676	0	0	0	194.08
194.10	07960	0	0	0	0	0	194.10
200.00							200.00
201.00							201.00
202.00		9,536,887	7,831,620	11,963,312	10,087,364	2,708,317	202.00
203.00		5,872.467365	0.094566	0.415490	0.006912	31.205763	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1

Date/Time Prepared:
5/29/2019 3:05 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
		(DIRECT NRSING HRS)					
204.00	Cost to be allocated (per Wkst. B, Part II)	324,981	1,441,198	1,692,271	954,761	185,568	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	200.111453	0.017402	0.058773	0.000654	2.138151	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: 15-0169

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

Worksheet B-1
Date/Time Prepared:
5/29/2019 3:05 pm

Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS			
		SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
		19.00	21.00		
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV		53,904		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV			53,904	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	35,247	35,247	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	35.00
40.00 04000	SUBPROVIDER - IPF	0	14,438	14,438	40.00
43.00 04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	0	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00 05700	CT SCAN	0	0	0	57.00
58.00 05800	MRI	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000	LABORATORY	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	74.00
76.00 03330	ENDOSCOPY	0	0	0	76.00
76.06 03954	IMAGING CENTER	0	0	0	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	0	0	0	90.00
90.26 04975	SPINE CENTER	0	0	0	90.26
91.00 09100	EMERGENCY	0	4,219	4,219	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				113.00
114.00 11400	UTILIZATION REVIEW-SNF				114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	53,904	53,904	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	194.00
194.06 07956	PAVILIONS	0	0	0	194.06
194.08 07958	OTHER NRCC	0	0	0	194.08
194.10 07960	COMMUNITY REHAB HOSPITAL	0	0	0	194.10
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1
Date/Time Prepared:
5/29/2019 3:05 pm

Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS			
		SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
		19.00	21.00		
202.00	Cost to be allocated (per Wkst. B, Part I)	0	517,829	791,627	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	9.606504	14.685867	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	6,701	10,244	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.124314	0.190042	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: 15-0169

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2019 3:05 pm

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		76,326,768	0	76,326,768	30.00
31.00	03100	INTENSIVE CARE UNIT		12,390,702	0	12,390,702	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		16,995,863	0	16,995,863	35.00
40.00	04000	SUBPROVIDER - IPF		3,965,799	0	3,965,799	40.00
43.00	04300	NURSERY		5,500,280	0	5,500,280	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		18,377,222	0	18,377,222	50.00
51.00	05100	RECOVERY ROOM		6,047,725	0	6,047,725	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		13,323,597	0	13,323,597	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		7,324,780	0	7,324,780	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		2,324,744	0	2,324,744	55.00
57.00	05700	CT SCAN		2,771,235	0	2,771,235	57.00
58.00	05800	MRI		1,908,200	0	1,908,200	58.00
59.00	05900	CARDIAC CATHETERIZATION		180,399	0	180,399	59.00
60.00	06000	LABORATORY		13,450,437	0	13,450,437	60.00
64.00	06400	INTRAVENOUS THERAPY		1,109,640	0	1,109,640	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,238,380	0	6,238,380	65.00
66.00	06600	PHYSICAL THERAPY	0	8,737,631	0	8,737,631	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,472,575	0	2,472,575	67.00
68.00	06800	SPEECH PATHOLOGY	0	475,511	0	475,511	68.00
69.00	06900	ELECTROCARDIOLOGY		869,983	0	869,983	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		2,805,299	0	2,805,299	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		26,675,607	0	26,675,607	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		17,899,862	0	17,899,862	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		25,520,378	0	25,520,378	73.00
74.00	07400	RENAL DIALYSIS		1,539,474	0	1,539,474	74.00
76.00	03330	ENDOSCOPY		3,595,093	0	3,595,093	76.00
76.06	03954	IMAGING CENTER		4,470,155	0	4,470,155	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER		10,192,916	0	10,192,916	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC		0	0	0	90.00
90.26	04975	SPINE CENTER		352,761	0	352,761	90.26
91.00	09100	EMERGENCY		17,403,727	0	17,403,727	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		7,756,070	0	7,756,070	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	0	319,002,813	0	319,002,813	200.00
201.00		Less Observation Beds		7,756,070		7,756,070	201.00
202.00		Total (see instructions)	0	311,246,743	0	311,246,743	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0169

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2019 3:05 pm

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	165,830,748		165,830,748		30.00
31.00	03100	INTENSIVE CARE UNIT	23,666,719		23,666,719		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	90,984,335		90,984,335		35.00
40.00	04000	SUBPROVIDER - I/PF	8,053,217		8,053,217		40.00
43.00	04300	NURSERY	9,847,218		9,847,218		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	124,545,112	64,028,631	188,573,743	0.097454	50.00
51.00	05100	RECOVERY ROOM	20,751,392	15,252,144	36,003,536	0.167976	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,890,363	0	22,890,363	0.582061	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,334,580	29,970,277	41,304,857	0.177335	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	13,806,724	17,715,934	31,522,658	0.073748	55.00
57.00	05700	CT SCAN	24,054,429	51,612,792	75,667,221	0.036624	57.00
58.00	05800	MRI	4,560,411	15,494,637	20,055,048	0.095148	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,538,853	0	2,538,853	0.071055	59.00
60.00	06000	LABORATORY	79,951,073	49,405,985	129,357,058	0.103979	60.00
64.00	06400	INTRAVENOUS THERAPY	940,072	135,372	1,075,444	1.031797	64.00
65.00	06500	RESPIRATORY THERAPY	27,101,391	2,696,998	29,798,389	0.209353	65.00
66.00	06600	PHYSICAL THERAPY	5,873,213	22,750,238	28,623,451	0.305261	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,121,206	2,969,537	8,090,743	0.305605	67.00
68.00	06800	SPEECH PATHOLOGY	1,542,336	803,061	2,345,397	0.202742	68.00
69.00	06900	ELECTROCARDIOLOGY	9,037,225	1,673,752	10,710,977	0.081223	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	989,174	11,787,312	12,776,486	0.219567	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	58,183,514	24,077,954	82,261,468	0.324278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,072,783	7,555,880	46,628,663	0.383881	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	81,103,033	30,414,257	111,517,290	0.228847	73.00
74.00	07400	RENAL DIALYSIS	3,466,226	0	3,466,226	0.444135	74.00
76.00	03330	ENDOSCOPY	4,708,315	19,327,414	24,035,729	0.149573	76.00
76.06	03954	IMAGING CENTER	362,351	52,693,089	53,055,440	0.084254	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	19,977	20,088,726	20,108,703	0.506891	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.26	04975	SPI NE CENTER	0	612,326	612,326	0.576100	90.26
91.00	09100	EMERGENCY	36,580,611	131,010,587	167,591,198	0.103846	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,607,178	8,872,565	10,479,743	0.740101	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	878,523,779	580,949,468	1,459,473,247		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	878,523,779	580,949,468	1,459,473,247		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 3:05 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
35.00	02060 NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000 SUBPROVIDER - I/PF			40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.097454		50.00
51.00	05100 RECOVERY ROOM	0.167976		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.582061		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.177335		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.073748		55.00
57.00	05700 CT SCAN	0.036624		57.00
58.00	05800 MRI	0.095148		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.071055		59.00
60.00	06000 LABORATORY	0.103979		60.00
64.00	06400 INTRAVENOUS THERAPY	1.031797		64.00
65.00	06500 RESPIRATORY THERAPY	0.209353		65.00
66.00	06600 PHYSICAL THERAPY	0.305261		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.305605		67.00
68.00	06800 SPEECH PATHOLOGY	0.202742		68.00
69.00	06900 ELECTROCARDIOLOGY	0.081223		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.219567		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.324278		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.383881		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.228847		73.00
74.00	07400 RENAL DIALYSIS	0.444135		74.00
76.00	03330 ENDOSCOPY	0.149573		76.00
76.06	03954 IMAGING CENTER	0.084254		76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.506891		76.07
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.26	04975 SPINE CENTER	0.576100		90.26
91.00	09100 EMERGENCY	0.103846		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.740101		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
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: 15-0169

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2019 3:05 pm

		Title XIX		Hospital		PPS
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	77,183,000		77,183,000	0	77,183,000 30.00
31.00	03100 INTENSIVE CARE UNIT	12,390,702		12,390,702	0	12,390,702 31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	16,995,863		16,995,863	0	16,995,863 35.00
40.00	04000 SUBPROVIDER - IPF	4,316,533		4,316,533	0	4,316,533 40.00
43.00	04300 NURSERY	5,500,280		5,500,280	0	5,500,280 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	18,377,222		18,377,222	0	18,377,222 50.00
51.00	05100 RECOVERY ROOM	6,047,725		6,047,725	0	6,047,725 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	13,323,597		13,323,597	0	13,323,597 52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,324,780		7,324,780	0	7,324,780 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,324,744		2,324,744	0	2,324,744 55.00
57.00	05700 CT SCAN	2,771,235		2,771,235	0	2,771,235 57.00
58.00	05800 MRI	1,908,200		1,908,200	0	1,908,200 58.00
59.00	05900 CARDIAC CATHETERIZATION	180,399		180,399	0	180,399 59.00
60.00	06000 LABORATORY	13,450,437		13,450,437	0	13,450,437 60.00
64.00	06400 INTRAVENOUS THERAPY	1,109,640		1,109,640	0	1,109,640 64.00
65.00	06500 RESPIRATORY THERAPY	6,238,380	0	6,238,380	0	6,238,380 65.00
66.00	06600 PHYSICAL THERAPY	8,737,631	0	8,737,631	0	8,737,631 66.00
67.00	06700 OCCUPATIONAL THERAPY	2,472,575	0	2,472,575	0	2,472,575 67.00
68.00	06800 SPEECH PATHOLOGY	475,511	0	475,511	0	475,511 68.00
69.00	06900 ELECTROCARDIOLOGY	869,983		869,983	0	869,983 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,805,299		2,805,299	0	2,805,299 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	26,675,607		26,675,607	0	26,675,607 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	17,899,862		17,899,862	0	17,899,862 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	25,520,378		25,520,378	0	25,520,378 73.00
74.00	07400 RENAL DIALYSIS	1,539,474		1,539,474	0	1,539,474 74.00
76.00	03330 ENDOSCOPY	3,595,093		3,595,093	0	3,595,093 76.00
76.06	03954 IMAGING CENTER	4,470,155		4,470,155	0	4,470,155 76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	10,192,916		10,192,916	0	10,192,916 76.07
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0		0	0	0 90.00
90.26	04975 SPINE CENTER	352,761		352,761	0	352,761 90.26
91.00	09100 EMERGENCY	17,506,217		17,506,217	0	17,506,217 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	7,756,070		7,756,070	0	7,756,070 92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
114.00	11400 UTILIZATION REVIEW-SNF					
200.00	Subtotal (see instructions)	320,312,269	0	320,312,269	0	320,312,269 200.00
201.00	Less Observation Beds	7,756,070		7,756,070	0	7,756,070 201.00
202.00	Total (see instructions)	312,556,199	0	312,556,199	0	312,556,199 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0169

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2019 3:05 pm

		Title XIX			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	165,830,748		165,830,748		30.00
31.00	03100	INTENSIVE CARE UNIT	23,666,719		23,666,719		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	90,984,335		90,984,335		35.00
40.00	04000	SUBPROVIDER - I PF	8,053,217		8,053,217		40.00
43.00	04300	NURSERY	9,847,218		9,847,218		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	124,545,112	64,028,631	188,573,743	0.097454	50.00
51.00	05100	RECOVERY ROOM	20,751,392	15,252,144	36,003,536	0.167976	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,890,363	0	22,890,363	0.582061	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,334,580	29,970,277	41,304,857	0.177335	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	13,806,724	17,715,934	31,522,658	0.073748	55.00
57.00	05700	CT SCAN	24,054,429	51,612,792	75,667,221	0.036624	57.00
58.00	05800	MRI	4,560,411	15,494,637	20,055,048	0.095148	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,538,853	0	2,538,853	0.071055	59.00
60.00	06000	LABORATORY	79,951,073	49,405,985	129,357,058	0.103979	60.00
64.00	06400	INTRAVENOUS THERAPY	940,072	135,372	1,075,444	1.031797	64.00
65.00	06500	RESPIRATORY THERAPY	27,101,391	2,696,998	29,798,389	0.209353	65.00
66.00	06600	PHYSICAL THERAPY	5,873,213	22,750,238	28,623,451	0.305261	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,121,206	2,969,537	8,090,743	0.305605	67.00
68.00	06800	SPEECH PATHOLOGY	1,542,336	803,061	2,345,397	0.202742	68.00
69.00	06900	ELECTROCARDIOLOGY	9,037,225	1,673,752	10,710,977	0.081223	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	989,174	11,787,312	12,776,486	0.219567	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	58,183,514	24,077,954	82,261,468	0.324278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,072,783	7,555,880	46,628,663	0.383881	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	81,103,033	30,414,257	111,517,290	0.228847	73.00
74.00	07400	RENAL DIALYSIS	3,466,226	0	3,466,226	0.444135	74.00
76.00	03330	ENDOSCOPY	4,708,315	19,327,414	24,035,729	0.149573	76.00
76.06	03954	IMAGING CENTER	362,351	52,693,089	53,055,440	0.084254	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	19,977	20,088,726	20,108,703	0.506891	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.26	04975	SPI NE CENTER	0	612,326	612,326	0.576100	90.26
91.00	09100	EMERGENCY	36,580,611	131,010,587	167,591,198	0.104458	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,607,178	8,872,565	10,479,743	0.740101	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	878,523,779	580,949,468	1,459,473,247		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	878,523,779	580,949,468	1,459,473,247		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 3:05 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000 SUBPROVIDER - I/PF			40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.097454		50.00
51.00	05100 RECOVERY ROOM	0.167976		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.582061		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.177335		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.073748		55.00
57.00	05700 CT SCAN	0.036624		57.00
58.00	05800 MRI	0.095148		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.071055		59.00
60.00	06000 LABORATORY	0.103979		60.00
64.00	06400 INTRAVENOUS THERAPY	1.031797		64.00
65.00	06500 RESPIRATORY THERAPY	0.209353		65.00
66.00	06600 PHYSICAL THERAPY	0.305261		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.305605		67.00
68.00	06800 SPEECH PATHOLOGY	0.202742		68.00
69.00	06900 ELECTROCARDIOLOGY	0.081223		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.219567		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.324278		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.383881		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.228847		73.00
74.00	07400 RENAL DIALYSIS	0.444135		74.00
76.00	03330 ENDOSCOPY	0.149573		76.00
76.06	03954 IMAGING CENTER	0.084254		76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.506891		76.07
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.26	04975 SPINE CENTER	0.576100		90.26
91.00	09100 EMERGENCY	0.104458		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.740101		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-0169

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

Worksheet C Part II Date/Time Prepared: 5/29/2019 3:05 pm

Cost Center Description		Title XIX					Hospital	PPS
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,377,222	2,301,187	16,076,035	0	0	50.00
51.00	05100	RECOVERY ROOM	6,047,725	718,023	5,329,702	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,323,597	1,825,946	11,497,651	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,324,780	845,082	6,479,698	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,324,744	543,662	1,781,082	0	0	55.00
57.00	05700	CT SCAN	2,771,235	329,349	2,441,886	0	0	57.00
58.00	05800	MRI	1,908,200	349,832	1,558,368	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	180,399	4,396	176,003	0	0	59.00
60.00	06000	LABORATORY	13,450,437	421,553	13,028,884	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,109,640	234,133	875,507	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,238,380	610,324	5,628,056	0	0	65.00
66.00	06600	PHYSICAL THERAPY	8,737,631	922,188	7,815,443	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,472,575	156,007	2,316,568	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	475,511	30,299	445,212	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	869,983	24,898	845,085	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,805,299	272,694	2,532,605	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,675,607	700,204	25,975,403	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,899,862	465,713	17,434,149	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,520,378	1,161,923	24,358,455	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,539,474	24,822	1,514,652	0	0	74.00
76.00	03330	ENDOSCOPY	3,595,093	557,263	3,037,830	0	0	76.00
76.06	03954	IMAGING CENTER	4,470,155	617,728	3,852,427	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	10,192,916	270,825	9,922,091	0	0	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.26	04975	SPINE CENTER	352,761	20,162	332,599	0	0	90.26
91.00	09100	EMERGENCY	17,506,217	1,659,551	15,846,666	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,756,070	916,767	6,839,303	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (sum of lines 50 thru 199)	203,925,891	15,984,531	187,941,360	0	0	200.00
201.00		Less Observation Beds	7,756,070	916,767	6,839,303	0	0	201.00
202.00		Total (line 200 minus line 201)	196,169,821	15,067,764	181,102,057	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-0169

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

Worksheet C Part II Date/Time Prepared: 5/29/2019 3:05 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	18,377,222	188,573,743	0.097454	50.00
51.00	05100 RECOVERY ROOM	6,047,725	36,003,536	0.167976	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	13,323,597	22,890,363	0.582061	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,324,780	41,304,857	0.177335	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,324,744	31,522,658	0.073748	55.00
57.00	05700 CT SCAN	2,771,235	75,667,221	0.036624	57.00
58.00	05800 MRI	1,908,200	20,055,048	0.095148	58.00
59.00	05900 CARDIAC CATHETERIZATION	180,399	2,538,853	0.071055	59.00
60.00	06000 LABORATORY	13,450,437	129,357,058	0.103979	60.00
64.00	06400 INTRAVENOUS THERAPY	1,109,640	1,075,444	1.031797	64.00
65.00	06500 RESPIRATORY THERAPY	6,238,380	29,798,389	0.209353	65.00
66.00	06600 PHYSICAL THERAPY	8,737,631	28,623,451	0.305261	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,472,575	8,090,743	0.305605	67.00
68.00	06800 SPEECH PATHOLOGY	475,511	2,345,397	0.202742	68.00
69.00	06900 ELECTROCARDIOLOGY	869,983	10,710,977	0.081223	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,805,299	12,776,486	0.219567	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	26,675,607	82,261,468	0.324278	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	17,899,862	46,628,663	0.383881	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	25,520,378	111,517,290	0.228847	73.00
74.00	07400 RENAL DIALYSIS	1,539,474	3,466,226	0.444135	74.00
76.00	03330 ENDOSCOPY	3,595,093	24,035,729	0.149573	76.00
76.06	03954 IMAGING CENTER	4,470,155	53,055,440	0.084254	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	10,192,916	20,108,703	0.506891	76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0.000000	90.00
90.26	04975 SPINE CENTER	352,761	612,326	0.576100	90.26
91.00	09100 EMERGENCY	17,506,217	167,591,198	0.104458	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	7,756,070	10,479,743	0.740101	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
114.00	11400 UTILIZATION REVIEW-SNF				114.00
200.00	Subtotal (sum of lines 50 thru 199)	203,925,891	1,161,091,010		200.00
201.00	Less Observation Beds	7,756,070	0		201.00
202.00	Total (line 200 minus line 201)	196,169,821	1,161,091,010		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part I Date/Time Prepared: 5/29/2019 3:05 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	9,021,804	0	9,021,804	63,523	142.02	30.00
31.00	INTENSIVE CARE UNIT	1,756,697		1,756,697	5,973	294.11	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	1,969,176		1,969,176	12,362	159.29	35.00
40.00	SUBPROVIDER - IPF	393,806	0	393,806	3,733	105.49	40.00
43.00	NURSERY	749,363		749,363	7,653	97.92	43.00
200.00	Total (lines 30 through 199)	13,890,846		13,890,846	93,244		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	19,318	2,743,542				
31.00	INTENSIVE CARE UNIT	2,041	600,279				
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				
40.00	SUBPROVIDER - IPF	2,614	275,751				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	23,973	3,619,572				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/29/2019 3:05 pm
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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		
Title XVIII Hospital PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,301,187	188,573,743	0.012203	45,194,925	551,514	50.00
51.00	05100	RECOVERY ROOM	718,023	36,003,536	0.019943	5,871,168	117,089	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,825,946	22,890,363	0.079769	53,468	4,265	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	845,082	41,304,857	0.020460	4,318,784	88,362	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	543,662	31,522,658	0.017247	5,601,213	96,604	55.00
57.00	05700	CT SCAN	329,349	75,667,221	0.004353	9,798,717	42,654	57.00
58.00	05800	MRI	349,832	20,055,048	0.017444	1,849,385	32,261	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,396	2,538,853	0.001731	1,406,802	2,435	59.00
60.00	06000	LABORATORY	421,553	129,357,058	0.003259	28,177,382	91,830	60.00
64.00	06400	INTRAVENOUS THERAPY	234,133	1,075,444	0.217708	288,573	62,825	64.00
65.00	06500	RESPIRATORY THERAPY	610,324	29,798,389	0.020482	6,530,868	133,765	65.00
66.00	06600	PHYSICAL THERAPY	922,188	28,623,451	0.032218	2,576,646	83,014	66.00
67.00	06700	OCCUPATIONAL THERAPY	156,007	8,090,743	0.019282	1,882,369	36,296	67.00
68.00	06800	SPEECH PATHOLOGY	30,299	2,345,397	0.012918	605,766	7,825	68.00
69.00	06900	ELECTROCARDIOLOGY	24,898	10,710,977	0.002325	4,091,553	9,513	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	272,694	12,776,486	0.021343	308,648	6,587	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	700,204	82,261,468	0.008512	15,917,177	135,487	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	465,713	46,628,663	0.009988	16,379,399	163,597	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,161,923	111,517,290	0.010419	25,139,962	261,933	73.00
74.00	07400	RENAL DIALYSIS	24,822	3,466,226	0.007161	1,797,657	12,873	74.00
76.00	03330	ENDOSCOPY	557,263	24,035,729	0.023185	306,862	7,115	76.00
76.06	03954	IMAGING CENTER	617,728	53,055,440	0.011643	43,696	509	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	270,825	20,108,703	0.013468	0	0	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.26	04975	SPI NE CENTER	20,162	612,326	0.032927	0	0	90.26
91.00	09100	EMERGENCY	1,659,551	167,591,198	0.009902	15,913,268	157,573	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	916,767	10,479,743	0.087480	484,644	42,397	92.00
200.00		Total (lines 50 through 199)	15,984,531	1,161,091,010		194,538,932	2,148,323	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Prepared: 5/29/2019 3:05 pm
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col. 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	63,523	0.00	19,318	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	5,973	0.00	2,041	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	12,362	0.00	0	35.00	
40.00	04000	SUBPROVIDER - IPF	0	0	3,733	0.00	2,614	40.00	
43.00	04300	NURSERY	0	0	7,653	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	93,244	0.00	23,973	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0						35.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:05 pm
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Cost Center Description	Title XVIII				Hospital		PPS	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health			
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
76.06	03954	IMAGING CENTER	0	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.26	04975	SPI NE CENTER	0	0	0	0	0	90.26
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:05 pm
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Cost Center Description		Title XVIII				Hospital	PPS	
		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	188,573,743	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	36,003,536	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	22,890,363	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	41,304,857	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	31,522,658	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	75,667,221	0.000000	57.00
58.00	05800	MRI	0	0	0	20,055,048	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,538,853	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	129,357,058	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,075,444	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	29,798,389	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	28,623,451	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8,090,743	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,345,397	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,710,977	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	12,776,486	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	82,261,468	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,628,663	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	111,517,290	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,466,226	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	24,035,729	0.000000	76.00
76.06	03954	IMAGING CENTER	0	0	0	53,055,440	0.000000	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	20,108,703	0.000000	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.26	04975	SPINE CENTER	0	0	0	612,326	0.000000	90.26
91.00	09100	EMERGENCY	0	0	0	167,591,198	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	10,479,743	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	1,161,091,010		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:05 pm
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Cost Center Description		Title XVIII			Hospital		PPS
		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	45,194,925	0	12,587,813	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	5,871,168	0	2,258,591	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	53,468	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	4,318,784	0	5,943,220	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	5,601,213	0	7,824,738	0	55.00
57.00	05700 CT SCAN	0.000000	9,798,717	0	10,297,115	0	57.00
58.00	05800 MRI	0.000000	1,849,385	0	3,663,749	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	1,406,802	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	28,177,382	0	8,796,100	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	288,573	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	6,530,868	0	271,209	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	2,576,646	0	97,812	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,882,369	0	51,564	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	605,766	0	15,125	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	4,091,553	0	300,426	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	308,648	0	2,399,994	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	15,917,177	0	5,046,910	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	16,379,399	0	2,809,833	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	25,139,962	0	8,291,831	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	1,797,657	0	0	0	74.00
76.00	03330 ENDOSCOPY	0.000000	306,862	0	5,706,847	0	76.00
76.06	03954 IMAGING CENTER	0.000000	43,696	0	14,310,155	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.000000	0	0	1,916,745	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.26	04975 SPINE CENTER	0.000000	0	0	3,619	0	90.26
91.00	09100 EMERGENCY	0.000000	15,913,268	0	16,661,634	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	484,644	0	3,682,973	0	92.00
200.00	Total (lines 50 through 199)		194,538,932	0	112,938,003	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 3:05 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	0.097454	12,587,813	0	0	1,226,733	50.00
51.00	05100	RECOVERY ROOM	0.167976	2,258,591	0	0	379,389	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.582061	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177335	5,943,220	0	0	1,053,941	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.073748	7,824,738	0	0	577,059	55.00
57.00	05700	CT SCAN	0.036624	10,297,115	0	0	377,122	57.00
58.00	05800	MRI	0.095148	3,663,749	0	0	348,598	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.071055	0	0	0	0	59.00
60.00	06000	LABORATORY	0.103979	8,796,100	0	0	914,610	60.00
64.00	06400	INTRAVENOUS THERAPY	1.031797	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.209353	271,209	0	0	56,778	65.00
66.00	06600	PHYSICAL THERAPY	0.305261	97,812	0	0	29,858	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.305605	51,564	0	0	15,758	67.00
68.00	06800	SPEECH PATHOLOGY	0.202742	15,125	0	0	3,066	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081223	300,426	0	0	24,402	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.219567	2,399,994	0	0	526,959	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.324278	5,046,910	0	0	1,636,602	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.383881	2,809,833	0	0	1,078,642	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228847	8,291,831	0	121,895	1,897,561	73.00
74.00	07400	RENAL DIALYSIS	0.444135	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.149573	5,706,847	0	0	853,590	76.00
76.06	03954	IMAGING CENTER	0.084254	14,310,155	0	0	1,205,688	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.506891	1,916,745	0	0	971,581	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.26	04975	SPINE CENTER	0.576100	3,619	0	0	2,085	90.26
91.00	09100	EMERGENCY	0.103846	16,661,634	0	0	1,730,244	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.740101	3,682,973	0	0	2,725,772	92.00
200.00		Subtotal (see instructions)		112,938,003	0	121,895	17,636,038	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		112,938,003	0	121,895	17,636,038	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 3:05 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
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	27,895		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03330 ENDOSCOPY	0	0		76.00
76.06 03954 IMAGING CENTER	0	0		76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0		76.07
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.26 04975 SPINE CENTER	0	0		90.26
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	0	27,895		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	27,895		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 15-0169 Component CCN: 15-S169		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part II Date/Time Prepared: 5/29/2019 3:05 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	2,301,187	188,573,743	0.012203	0	0	50.00
51.00	05100	RECOVERY ROOM	718,023	36,003,536	0.019943	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,825,946	22,890,363	0.079769	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	845,082	41,304,857	0.020460	33,606	688	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	543,662	31,522,658	0.017247	0	0	55.00
57.00	05700	CT SCAN	329,349	75,667,221	0.004353	87,949	383	57.00
58.00	05800	MRI	349,832	20,055,048	0.017444	8,489	148	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,396	2,538,853	0.001731	0	0	59.00
60.00	06000	LABORATORY	421,553	129,357,058	0.003259	826,848	2,695	60.00
64.00	06400	INTRAVENOUS THERAPY	234,133	1,075,444	0.217708	18,684	4,068	64.00
65.00	06500	RESPIRATORY THERAPY	610,324	29,798,389	0.020482	25,891	530	65.00
66.00	06600	PHYSICAL THERAPY	922,188	28,623,451	0.032218	78,395	2,526	66.00
67.00	06700	OCCUPATIONAL THERAPY	156,007	8,090,743	0.019282	74,941	1,445	67.00
68.00	06800	SPEECH PATHOLOGY	30,299	2,345,397	0.012918	6,527	84	68.00
69.00	06900	ELECTROCARDIOLOGY	24,898	10,710,977	0.002325	17,686	41	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	272,694	12,776,486	0.021343	4,598	98	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	700,204	82,261,468	0.008512	106,027	903	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	465,713	46,628,663	0.009988	600	6	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,161,923	111,517,290	0.010419	591,469	6,163	73.00
74.00	07400	RENAL DIALYSIS	24,822	3,466,226	0.007161	0	0	74.00
76.00	03330	ENDOSCOPY	557,263	24,035,729	0.023185	0	0	76.00
76.06	03954	IMAGING CENTER	617,728	53,055,440	0.011643	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	270,825	20,108,703	0.013468	0	0	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.26	04975	SPINE CENTER	20,162	612,326	0.032927	0	0	90.26
91.00	09100	EMERGENCY	1,659,551	167,591,198	0.009902	244,191	2,418	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,479,743	0.000000	21,097	0	92.00
200.00		Total (lines 50 through 199)	15,067,764	1,161,091,010		2,146,998	22,196	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:05 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
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 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
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03330 ENDOSCOPY	0	0	0	0	0	76.00
76.06 03954 IMAGING CENTER	0	0	0	0	0	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.26 04975 SPINE CENTER	0	0	0	0	0	90.26
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:05 pm
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	188,573,743	0.000000 50.00
51.00	05100	RECOVERY ROOM	0	0	0	36,003,536	0.000000 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	22,890,363	0.000000 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	41,304,857	0.000000 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	31,522,658	0.000000 55.00
57.00	05700	CT SCAN	0	0	0	75,667,221	0.000000 57.00
58.00	05800	MRI	0	0	0	20,055,048	0.000000 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,538,853	0.000000 59.00
60.00	06000	LABORATORY	0	0	0	129,357,058	0.000000 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,075,444	0.000000 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	29,798,389	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	28,623,451	0.000000 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8,090,743	0.000000 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,345,397	0.000000 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,710,977	0.000000 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	12,776,486	0.000000 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	82,261,468	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,628,663	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	111,517,290	0.000000 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,466,226	0.000000 74.00
76.00	03330	ENDOSCOPY	0	0	0	24,035,729	0.000000 76.00
76.06	03954	IMAGING CENTER	0	0	0	53,055,440	0.000000 76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	20,108,703	0.000000 76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0.000000 90.00
90.26	04975	SPI NE CENTER	0	0	0	612,326	0.000000 90.26
91.00	09100	EMERGENCY	0	0	0	167,591,198	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	10,479,743	0.000000 92.00
200.00		Total (lines 50 through 199)	0	0	0	1,161,091,010	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:05 pm
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Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	33,606	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	87,949	0	0	0	57.00
58.00	05800 MRI	0.000000	8,489	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	826,848	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	18,684	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	25,891	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	78,395	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	74,941	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	6,527	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	17,686	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	4,598	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	106,027	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	600	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	591,469	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03330 ENDOSCOPY	0.000000	0	0	0	0	76.00
76.06	03954 IMAGING CENTER	0.000000	0	0	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.000000	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.26	04975 SPINE CENTER	0.000000	0	0	0	0	90.26
91.00	09100 EMERGENCY	0.000000	244,191	0	2,645	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	21,097	0	0	0	92.00
200.00	Total (lines 50 through 199)		2,146,998	0	2,645	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 3:05 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	0.097454	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.167976	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.582061	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177335	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.073748	0	0	0	55.00
57.00	05700	CT SCAN	0.036624	0	0	0	57.00
58.00	05800	MRI	0.095148	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.071055	0	0	0	59.00
60.00	06000	LABORATORY	0.103979	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1.031797	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.209353	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.305261	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.305605	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.202742	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081223	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.219567	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.324278	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.383881	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228847	0	0	6,685	73.00
74.00	07400	RENAL DIALYSIS	0.444135	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.149573	0	0	0	76.00
76.06	03954	IMAGING CENTER	0.084254	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.506891	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	90.00
90.26	04975	SPI NE CENTER	0.576100	0	0	0	90.26
91.00	09100	EMERGENCY	0.103846	2,645	0	0	275 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.740101	0	0	0	92.00
200.00		Subtotal (see instructions)		2,645	0	6,685	275 200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		2,645	0	6,685	275 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 3:05 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
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1,530	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03330 ENDOSCOPY	0	0	76.00
76.06 03954 IMAGING CENTER	0	0	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	76.07
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
90.26 04975 SPINE CENTER	0	0	90.26
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Subtotal (see instructions)	0	1,530	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	1,530	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part I Date/Time Prepared: 5/29/2019 3:05 pm
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Cost Center Description		Title XIX			Hospital		Per Diem (col. 3 / col. 4)	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	9,021,804	0	9,021,804	63,523	142.02	30.00	
31.00	INTENSIVE CARE UNIT	1,756,697		1,756,697	5,973	294.11	31.00	
35.00	NEONATAL INTENSIVE CARE UNIT	1,969,176		1,969,176	12,362	159.29	35.00	
40.00	SUBPROVIDER - IPF	393,806	0	393,806	3,733	105.49	40.00	
43.00	NURSERY	749,363		749,363	7,653	97.92	43.00	
200.00	Total (lines 30 through 199)	13,890,846		13,890,846	93,244		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	1,012	143,724					
31.00	INTENSIVE CARE UNIT	0	0					
35.00	NEONATAL INTENSIVE CARE UNIT	605	96,370					
40.00	SUBPROVIDER - IPF	0	0					
43.00	NURSERY	3,288	321,961					
200.00	Total (lines 30 through 199)	4,905	562,055					

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/29/2019 3:05 pm
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,301,187	188,573,743	0.012203	1,403,694	17,129	50.00
51.00	05100	RECOVERY ROOM	718,023	36,003,536	0.019943	211,950	4,227	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,825,946	22,890,363	0.079769	391,897	31,261	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	845,082	41,304,857	0.020460	222,541	4,553	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	543,662	31,522,658	0.017247	336,058	5,796	55.00
57.00	05700	CT SCAN	329,349	75,667,221	0.004353	426,696	1,857	57.00
58.00	05800	MRI	349,832	20,055,048	0.017444	49,670	866	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,396	2,538,853	0.001731	0	0	59.00
60.00	06000	LABORATORY	421,553	129,357,058	0.003259	1,628,858	5,308	60.00
64.00	06400	INTRAVENOUS THERAPY	234,133	1,075,444	0.0217708	15,392	3,351	64.00
65.00	06500	RESPIRATORY THERAPY	610,324	29,798,389	0.020482	1,034,622	21,191	65.00
66.00	06600	PHYSICAL THERAPY	922,188	28,623,451	0.032218	79,118	2,549	66.00
67.00	06700	OCCUPATIONAL THERAPY	156,007	8,090,743	0.019282	115,763	2,232	67.00
68.00	06800	SPEECH PATHOLOGY	30,299	2,345,397	0.012918	35,145	454	68.00
69.00	06900	ELECTROCARDIOLOGY	24,898	10,710,977	0.002325	167,592	390	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	272,694	12,776,486	0.021343	32,173	687	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	700,204	82,261,468	0.008512	812,504	6,916	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	465,713	46,628,663	0.009988	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,161,923	111,517,290	0.010419	2,096,639	21,845	73.00
74.00	07400	RENAL DIALYSIS	24,822	3,466,226	0.007161	28,120	201	74.00
76.00	03330	ENDOSCOPY	557,263	24,035,729	0.023185	42,061	975	76.00
76.06	03954	IMAGING CENTER	617,728	53,055,440	0.011643	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	270,825	20,108,703	0.013468	0	0	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.26	04975	SPINE CENTER	20,162	612,326	0.032927	0	0	90.26
91.00	09100	EMERGENCY	1,659,551	167,591,198	0.009902	732,756	7,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	916,762	10,479,743	0.087479	44,022	3,851	92.00
200.00		Total (lines 50 through 199)	15,984,526	1,161,091,010		9,907,271	142,895	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Prepared: 5/29/2019 3:05 pm
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col. 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	63,523	0.00	1,012	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	5,973	0.00	0	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	12,362	0.00	605	35.00	
40.00	04000	SUBPROVIDER - IPF	0	0	3,733	0.00	0	40.00	
43.00	04300	NURSERY	0	0	7,653	0.00	3,288	43.00	
200.00		Total (lines 30 through 199)	0	0	93,244	0.00	4,905	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0						35.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:05 pm
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Cost Center Description	Title XIX				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 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
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03330 ENDOSCOPY	0	0	0	0	0	76.00
76.06	03954 IMAGING CENTER	0	0	0	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.26	04975 SPINE CENTER	0	0	0	0	0	90.26
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:05 pm
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Cost Center Description		Title XIX			Hospital	PPS		
		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	188,573,743	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	36,003,536	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	22,890,363	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	41,304,857	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	31,522,658	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	75,667,221	0.000000	57.00
58.00	05800	MRI	0	0	0	20,055,048	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,538,853	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	129,357,058	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,075,444	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	29,798,389	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	28,623,451	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8,090,743	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,345,397	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,710,977	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	12,776,486	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	82,261,468	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,628,663	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	111,517,290	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,466,226	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	24,035,729	0.000000	76.00
76.06	03954	IMAGING CENTER	0	0	0	53,055,440	0.000000	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	20,108,703	0.000000	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.26	04975	SPI NE CENTER	0	0	0	612,326	0.000000	90.26
91.00	09100	EMERGENCY	0	0	0	167,591,198	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	10,479,743	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	1,161,091,010		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:05 pm
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Cost Center Description		Title XIX			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	1,403,694	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	211,950	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	391,897	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	222,541	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	336,058	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	426,696	0	0	0	57.00
58.00	05800 MRI	0.000000	49,670	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	1,628,858	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	15,392	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	1,034,622	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	79,118	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	115,763	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	35,145	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	167,592	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	32,173	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	812,504	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	2,096,639	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	28,120	0	0	0	74.00
76.00	03330 ENDOSCOPY	0.000000	42,061	0	0	0	76.00
76.06	03954 IMAGING CENTER	0.000000	0	0	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.000000	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.26	04975 SPINE CENTER	0.000000	0	0	0	0	90.26
91.00	09100 EMERGENCY	0.000000	732,756	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	44,022	0	0	0	92.00
200.00	Total (lines 50 through 199)		9,907,271	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 3:05 pm
		Title XIX	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	0.097454	0	673,336	0	0
51.00 05100 RECOVERY ROOM	0.167976	0	149,839	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.582061	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.177335	0	612,216	0	0
55.00 05500 RADIOLOGY-THERAPEUTIC	0.073748	0	252,294	0	0
57.00 05700 CT SCAN	0.036624	0	1,125,596	0	0
58.00 05800 MRI	0.095148	0	167,149	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.071055	0	0	0	0
60.00 06000 LABORATORY	0.103979	0	1,224,737	0	0
64.00 06400 INTRAVENOUS THERAPY	1.031797	0	9,457	0	0
65.00 06500 RESPIRATORY THERAPY	0.209353	0	52,414	0	0
66.00 06600 PHYSICAL THERAPY	0.305261	0	181,896	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.305605	0	70,744	0	0
68.00 06800 SPEECH PATHOLOGY	0.202742	0	31,653	0	0
69.00 06900 ELECTROCARDIOLOGY	0.081223	0	27,856	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.219567	0	83,810	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.324278	0	207,190	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.383881	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.228847	0	377,174	0	0
74.00 07400 RENAL DIALYSIS	0.444135	0	0	0	0
76.00 03330 ENDOSCOPY	0.149573	0	101,345	0	0
76.06 03954 IMAGING CENTER	0.084254	0	394,112	0	0
76.07 03955 BREAST DIAGNOSTIC CENTER	0.506891	0	97,680	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.000000	0	0	0	0
90.26 04975 SPINE CENTER	0.576100	0	0	0	0
91.00 09100 EMERGENCY	0.104458	0	4,074,477	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.740101	0	114,176	0	0
200.00 Subtotal (see instructions)		0	10,029,151	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 - line 201)		0	10,029,151	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 3:05 pm
		Title XIX	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	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	65,619	0	50.00
51.00	05100 RECOVERY ROOM	25,169	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	108,567	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	18,606	0	55.00
57.00	05700 CT SCAN	41,224	0	57.00
58.00	05800 MRI	15,904	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	127,347	0	60.00
64.00	06400 INTRAVENOUS THERAPY	9,758	0	64.00
65.00	06500 RESPIRATORY THERAPY	10,973	0	65.00
66.00	06600 PHYSICAL THERAPY	55,526	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	21,620	0	67.00
68.00	06800 SPEECH PATHOLOGY	6,417	0	68.00
69.00	06900 ELECTROCARDIOLOGY	2,263	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	18,402	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	67,187	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	86,315	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03330 ENDOSCOPY	15,158	0	76.00
76.06	03954 IMAGING CENTER	33,206	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	49,513	0	76.07
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.26	04975 SPINE CENTER	0	0	90.26
91.00	09100 EMERGENCY	425,612	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	84,502	0	92.00
200.00	Subtotal (see instructions)	1,288,888	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)	1,288,888	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2019 3:05 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		63,523	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		63,523	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)		57,068	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)		19,318	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)		76,326,768	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)		76,326,768	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)		76,326,768	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)		1,201.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		23,211,736	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)		23,211,736	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0169		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1	
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		12,390,702	5,973	2,074.45	2,041	4,233,952	43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	NEONATAL INTENSIVE CARE UNIT		16,995,863	12,362	1,374.85	0	0	47.00
Cost Center Description								
							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						33,776,822	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						61,222,510	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)						3,343,821	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						2,148,323	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						5,492,144	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						55,730,366	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)						6,455	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,201.56	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						7,756,070	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/29/2019 3:05 pm	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	9,021,804	76,326,768	0.118200	7,756,070	916,767	90.00
91.00	Nursing School cost	0	76,326,768	0.000000	7,756,070	0	91.00
92.00	Allied health cost	0	76,326,768	0.000000	7,756,070	0	92.00
93.00	All other Medical Education	0	76,326,768	0.000000	7,756,070	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 3:05 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)			3,733 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,733 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)			3,733 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)			2,614 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)			3,965,799 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)			3,965,799 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)			3,965,799 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)			1,062.36 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,777,009 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)			2,777,009 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169 Component CCN: 15-S169		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/29/2019 3:05 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	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	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				382,205		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				3,159,214		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)				275,751		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				22,196		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				297,947		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				2,861,267		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: 15-0169 Component CCN: 15-S169		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/29/2019 3:05 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	393,806	3,965,799	0.099301	0	0	90.00
91.00	Nursing School cost	0	3,965,799	0.000000	0	0	91.00
92.00	Allied health cost	0	3,965,799	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,965,799	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 3:05 pm
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		63,523	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		63,523	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)		57,068	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)		1,012	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)		7,653	15.00
16.00	Nursery days (title V or XIX only)		3,288	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)		77,183,000	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)		77,183,000	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)		77,183,000	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)		1,215.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,229,620	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,229,620	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 3:05 pm	
				Title XIX	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)		
42.00	NURSERY (title V & XIX only)	5,500,280	7,653	718.71	3,288	2,363,118	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	12,390,702	5,973	2,074.45	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	NEONATAL INTENSIVE CARE UNIT	16,995,863	12,362	1,374.85	605	831,784	47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,845,478	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,270,000	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)					562,055	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					142,895	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					704,950	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,565,050	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)					6,455	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,215.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					7,843,083	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/29/2019 3:05 pm	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	9,021,804	77,183,000	0.116888	7,843,083	916,762	90.00
91.00	Nursing School cost	0	77,183,000	0.000000	7,843,083	0	91.00
92.00	Allied health cost	0	77,183,000	0.000000	7,843,083	0	92.00
93.00	All other Medical Education	0	77,183,000	0.000000	7,843,083	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/29/2019 3:05 pm	
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		38,397,826	30.00
31.00	03100	INTENSIVE CARE UNIT		7,860,443	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
40.00	04000	SUBPROVIDER - I/PF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.097454	45,194,925	50.00
51.00	05100	RECOVERY ROOM	0.167976	5,871,168	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.582061	53,468	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177335	4,318,784	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.073748	5,601,213	55.00
57.00	05700	CT SCAN	0.036624	9,798,717	57.00
58.00	05800	MRI	0.095148	1,849,385	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.071055	1,406,802	59.00
60.00	06000	LABORATORY	0.103979	28,177,382	60.00
64.00	06400	INTRAVENOUS THERAPY	1.031797	288,573	64.00
65.00	06500	RESPIRATORY THERAPY	0.209353	6,530,868	65.00
66.00	06600	PHYSICAL THERAPY	0.305261	2,576,646	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.305605	1,882,369	67.00
68.00	06800	SPEECH PATHOLOGY	0.202742	605,766	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081223	4,091,553	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.219567	308,648	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.324278	15,917,177	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.383881	16,379,399	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228847	25,139,962	73.00
74.00	07400	RENAL DIALYSIS	0.444135	1,797,657	74.00
76.00	03330	ENDOSCOPY	0.149573	306,862	76.00
76.06	03954	IMAGING CENTER	0.084254	43,696	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.506891	0	76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.26	04975	SPI NE CENTER	0.576100	0	90.26
91.00	09100	EMERGENCY	0.103846	15,913,268	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.740101	484,644	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		194,538,932	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)		194,538,932	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/29/2019 3:05 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
35.00	02060 NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000 SUBPROVIDER - IPF		5,664,871		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.097454	0	0	50.00
51.00	05100 RECOVERY ROOM	0.167976	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.582061	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.177335	33,606	5,960	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.073748	0	0	55.00
57.00	05700 CT SCAN	0.036624	87,949	3,221	57.00
58.00	05800 MRI	0.095148	8,489	808	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.071055	0	0	59.00
60.00	06000 LABORATORY	0.103979	826,848	85,975	60.00
64.00	06400 INTRAVENOUS THERAPY	1.031797	18,684	19,278	64.00
65.00	06500 RESPIRATORY THERAPY	0.209353	25,891	5,420	65.00
66.00	06600 PHYSICAL THERAPY	0.305261	78,395	23,931	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.305605	74,941	22,902	67.00
68.00	06800 SPEECH PATHOLOGY	0.202742	6,527	1,323	68.00
69.00	06900 ELECTROCARDIOLOGY	0.081223	17,686	1,437	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.219567	4,598	1,010	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.324278	106,027	34,382	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.383881	600	230	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.228847	591,469	135,356	73.00
74.00	07400 RENAL DIALYSIS	0.444135	0	0	74.00
76.00	03330 ENDOSCOPY	0.149573	0	0	76.00
76.06	03954 IMAGING CENTER	0.084254	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.506891	0	0	76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.26	04975 SPINE CENTER	0.576100	0	0	90.26
91.00	09100 EMERGENCY	0.103846	244,191	25,358	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.740101	21,097	15,614	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,146,998	382,205	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		2,146,998		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/29/2019 3:05 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		3,681,825	30.00
31.00	03100	INTENSIVE CARE UNIT		660,760	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		6,524,711	35.00
40.00	04000	SUBPROVIDER - I/PF		65,208	40.00
43.00	04300	NURSERY		419,312	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.097454	1,403,694	136,796 50.00
51.00	05100	RECOVERY ROOM	0.167976	211,950	35,603 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.582061	391,897	228,108 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177335	222,541	39,464 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.073748	336,058	24,784 55.00
57.00	05700	CT SCAN	0.036624	426,696	15,627 57.00
58.00	05800	MRI	0.095148	49,670	4,726 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.071055	0	0 59.00
60.00	06000	LABORATORY	0.103979	1,628,858	169,367 60.00
64.00	06400	INTRAVENOUS THERAPY	1.031797	15,392	15,881 64.00
65.00	06500	RESPIRATORY THERAPY	0.209353	1,034,622	216,601 65.00
66.00	06600	PHYSICAL THERAPY	0.305261	79,118	24,152 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.305605	115,763	35,378 67.00
68.00	06800	SPEECH PATHOLOGY	0.202742	35,145	7,125 68.00
69.00	06900	ELECTROCARDIOLOGY	0.081223	167,592	13,612 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.219567	32,173	7,064 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.324278	812,504	263,477 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.383881	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228847	2,096,639	479,810 73.00
74.00	07400	RENAL DIALYSIS	0.444135	28,120	12,489 74.00
76.00	03330	ENDOSCOPY	0.149573	42,061	6,291 76.00
76.06	03954	IMAGING CENTER	0.084254	0	0 76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.506891	0	0 76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.26	04975	SPI NE CENTER	0.576100	0	0 90.26
91.00	09100	EMERGENCY	0.104458	732,756	76,542 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.740101	44,022	32,581 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,907,271	1,845,478 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		9,907,271	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 3:05 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		32,981,412	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		10,912,271	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)		1,399,379	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		15,598,570	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		261.00	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).		3.25	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)		3.25	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		2.85	10.00
11.00	FTE count for residents in dental and podiatric programs.		2.54	11.00
12.00	Current year allowable FTE (see instructions)		5.39	12.00
13.00	Total allowable FTE count for the prior year.		4.94	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.		4.38	14.00
15.00	Sum of lines 12 through 14 divided by 3.		4.90	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		4.90	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.018774	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.018853	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.018774	21.00
22.00	IME payment adjustment (see instructions)		448,023	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		159,215	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)		-0.40	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)		448,023	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		159,215	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.88	30.00
31.00	Percentage of Medicaid patient days (see instructions)		29.39	31.00
32.00	Sum of lines 30 and 31		33.27	32.00
33.00	Allowable disproportionate share percentage (see instructions)		16.66	33.00
34.00	Disproportionate share adjustment (see instructions)		1,828,172	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 3:05 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)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000438215	0.000343050	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,965,267	2,838,006	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	2,217,857	715,334	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,933,191		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 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 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 and 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)	50,502,448		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)		50,661,663	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		4,027,525	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).		127,949	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		14,979	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 instructions)		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)		54,832,116	59.00
60.00	Primary payer payments		16,601	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		54,815,515	61.00
62.00	Deductibles billed to program beneficiaries		4,278,760	62.00
63.00	Coinurance billed to program beneficiaries		92,107	63.00
64.00	Allowable bad debts (see instructions)		149,416	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		97,120	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		93,062	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		50,541,768	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)		0	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)		-391,243	70.93
70.94	HRR adjustment amount (see instructions)		-414,529	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 3:05 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	1.00	0 70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0 70.97
70.98	Low Volume Payment-3			0 70.98
70.99	HAC adjustment amount (see instructions)		535,413	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		49,200,583	71.00
71.01	Sequestration adjustment (see instructions)		984,012	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		47,999,167	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)		217,404	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		489,444	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
Comparison 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 3:05 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		27,895	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		17,636,038	2.00
3.00	OPPS payments		15,320,553	3.00
4.00	Outlier payment (see instructions)		32,565	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)		27,895	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		121,895	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)		121,895	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 charge basis 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)		121,895	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		94,000	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)		27,895	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)		15,353,118	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)		2,957,446	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		12,423,567	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		35,111	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)		12,458,678	30.00
31.00	Primary payer payments		3,188	31.00
32.00	Subtotal (line 30 minus line 31)		12,455,490	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)		284,976	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		185,234	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		264,422	36.00
37.00	Subtotal (see instructions)		12,640,724	37.00
38.00	MSP-LCC reconciliation amount from PS&R		97	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	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)		12,640,627	40.00
40.01	Sequestration adjustment (see instructions)		252,813	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		12,368,812	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		19,002	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: 15-0169 Component CCN: 15-S169	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 3:05 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,530	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		275	2.00
3.00	OPPS payments		1,041	3.00
4.00	Outlier payment (see instructions)		21,524	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,530	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		6,685	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)		6,685	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 charge basis 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)		6,685	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		5,155	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		1,530	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)		22,565	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)		24,095	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)		24,095	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		24,095	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)		24,095	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)		24,095	40.00
40.01	Sequestration adjustment (see instructions)		482	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		2,871	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		20,742	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0169

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2019 3:05 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		47,999,167		12,368,812	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)		47,999,167		12,368,812	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		217,404		19,002	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		48,216,571		12,387,814	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: 15-0169
Component CCN: 15-S169

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2019 3:05 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					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		2,260,110		2,871	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)		2,260,110		2,871	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		3,506		20,742	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,263,616		23,613	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: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/29/2019 3:05 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: 15-0169 Component CCN: 15-S169	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part II Date/Time Prepared: 5/29/2019 3:05 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)			2,527,777 1.00
2.00	Net IPF PPS Outlier Payments			21,524 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 instructions)			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 instructions)			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)			10.227397 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			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)			2,549,301 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)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,549,301 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,549,301 18.00
19.00	Deductibles			199,516 19.00
20.00	Subtotal (line 18 minus line 19)			2,349,785 20.00
21.00	Coinsurance			43,550 21.00
22.00	Subtotal (line 20 minus line 21)			2,306,235 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			5,503 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			3,577 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			5,168 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,309,812 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)			2,309,812 31.00
31.01	Sequestration adjustment (see instructions)			46,196 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			2,260,110 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)			3,506 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			21,524 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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet E-4 Date/Time Prepared: 5/29/2019 3:05 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			3.25	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			3.25	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			2.85	6.00
7.00	Enter the lesser of line 5 or line 6			2.85	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	1.27	1.58	2.85	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	1.27	1.58	2.85	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		2.54		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		2.54		10.01
11.00	Total weighted FTE count	1.27	4.12		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	1.42	3.12		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.04	2.61		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	1.24	3.28		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	1.24	3.28		17.00
18.00	Per resident amount	93,984.35	93,984.35		18.00
19.00	Approved amount for resident costs	116,541	308,269	424,810	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			424,810	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	23,973	8,057		26.00
27.00	Total Inpatient Days (see instructions)	80,480	80,480		27.00
28.00	Ratio of inpatient days to total inpatient days	0.297875	0.100112		28.00
29.00	Program direct GME amount	126,540	42,529		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		6,009		30.00
31.00	Net Program direct GME amount			163,060	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet E-4 Date/Time Prepared: 5/29/2019 3:05 pm
		Title XVIII	Hospital	PPS
		1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		3,466,226	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		64,381,724	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		16,601	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		64,365,123	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		17,665,738	42.00
43.00	Primary payer payments (see instructions)		3,188	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		17,662,550	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		82,027,673	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.784676	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.215324	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		163,060	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		127,949	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		35,111	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-0169

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

Worksheet G

Date/Time Prepared:
5/29/2019 3:05 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	9,020	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,725,816,418	0	0	0	4.00
5.00	Other receivable	-217,170,947	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	878,062	0	0	0	6.00
7.00	Inventory	5,786,797	0	0	0	7.00
8.00	Prepaid expenses	15,050	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,515,334,400	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,705,851	0	0	0	12.00
13.00	Land improvements	3,747,533	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	320,765,033	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	2,597,127	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	111,222,719	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	77,200	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	-224,838,346	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	316,270	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	216,593,387	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	-573,517,965	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-573,517,965	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	1,158,409,822	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,664,540	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	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	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,099,858	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,764,398	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,764,398	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	1,154,645,424	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	1,154,645,424	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	1,158,409,822	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0169

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

Worksheet G-1

Date/Time Prepared:
5/29/2019 3:05 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		1,030,678,250		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		123,967,172			2.00
3.00	Total (sum of line 1 and line 2)		1,154,645,422		0	3.00
4.00	ROUNDING	2		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		2		0	10.00
11.00	Subtotal (line 3 plus line 10)		1,154,645,424		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		1,154,645,424		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	ROUNDING		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: 15-0169

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2019 3:05 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	162,916,788		162,916,788	1.00
2.00	SUBPROVIDER - IPF	8,052,981		8,052,981	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	170,969,769		170,969,769	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	24,756,880		24,756,880	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	NEONATAL INTENSIVE CARE UNIT	94,060,102		94,060,102	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	118,816,982		118,816,982	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	289,786,751		289,786,751	17.00
18.00	Ancillary services	580,484,538	633,355,100	1,213,839,638	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	870,271,289	633,355,100	1,503,626,389	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		347,777,026		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)		347,777,026		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0169

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

Worksheet G-3

Date/Time Prepared:
5/29/2019 3:05 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,503,626,389	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,036,595,941	2.00
3.00	Net patient revenues (line 1 minus line 2)	467,030,448	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	347,777,026	4.00
5.00	Net income from service to patients (line 3 minus line 4)	119,253,422	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	186,376	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	26,173	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	2,372,374	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	MISC REVENUE	2,128,827	24.00
25.00	Total other income (sum of lines 6-24)	4,713,750	25.00
26.00	Total (line 5 plus line 25)	123,967,172	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)	123,967,172	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/29/2019 3:05 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,574,520	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		180,984	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)		215.81	3.00
4.00	Number of interns & residents (see instructions)		4.90	4.00
5.00	Indirect medical education percentage (see instructions)		0.64	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)		22,877	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.88	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		29.39	8.00
9.00	Sum of lines 7 and 8		33.27	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.97	10.00
11.00	Disproportionate share adjustment (see instructions)		249,144	11.00
12.00	Total prospective capital payments (see instructions)		4,027,525	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