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: 15-0150	Period: From 04/01/2017 To 03/31/2018	Worksheet S Parts I-III Date/Time Prepared: 8/31/2018 12:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/31/2018 Time: 12:05 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DUPONT HOSPITAL (15-0150) for the cost reporting period beginning 04/01/2017 and ending 03/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	161,215	-10,328	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	161,215	-10,328	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: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2018 12:02 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2520 E. DUPONT ROAD	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46825-	County: ALLEN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	DUPONT HOSPITAL	150150	23060	1	05/24/2001	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2017	03/31/2018	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	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	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	568	368	24	80	6,575	303	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2018 12:02 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2018 12:02 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2018 12:02 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	0.00	0.000000	66.00

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2018 12:02 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:	53,551	95,918	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.	Y	5.03	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	449008	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2018 12:02 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS, INC	Contractor's Number: 10301	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 8/31/2018 12:02 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	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	06/18/2018	Y	06/18/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 8/31/2018 12:02 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2017	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KUZIWA	TSIGA	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS, INC.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 465-3416	KUZIWA_TSIGA@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0150	Period: From 04/01/2017 To 03/31/2018	Worksheet S-2 Part II Date/Time Prepared: 8/31/2018 12:02 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER - REVENUE MANAGEMENT		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: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2018 12:02 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	92	33,580	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)		92	33,580	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
8.01	NEONATAL INTENSIVE CARE UNIT	31.01	29	10,585	0.00	0	8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		131	47,815	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		131				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: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2018 12:02 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)	1,878	71	10,245			1.00
2.00	HMO and other (see instructions)	1,278	5,162				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)	1,878	71	10,245			7.00
8.00	INTENSIVE CARE UNIT	210	49	1,281			8.00
8.01	NEONATAL INTENSIVE CARE UNIT	0	164	5,906			8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		2,169	4,357			13.00
14.00	Total (see instructions)	2,088	2,453	21,789	0.00	593.36	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	593.36	27.00
28.00	Observation Bed Days		0	2,359			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	303	875			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: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2018 12:02 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	554	958	4,526	1.00
2.00	HMO and other (see instructions)			0	0		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
8.01	NEONATAL INTENSIVE CARE UNIT						8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	554	958	4,526	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 8/31/2018 12:02 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	35,891,840	0	35,891,840	1,234,213.00	29.08	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	-1,025	1,025	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,370	546,737	550,107	16,276.00	33.80	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		393,115	0	393,115	7,180.00	54.75	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		282,961	0	282,961	1,049.00	269.74	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		3,304,602	0	3,304,602	97,039.00	34.05	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,862,438	0	7,862,438			17.00
18.00	Wage-related costs (other) (see instructions)		200,655	0	200,655			18.00
19.00	Excluded areas		118,812	0	118,812			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	198,096	0	198,096	7,085.00	27.96	26.00
27.00	Administrative & General	5.00	5,101,110	-658,518	4,442,592	155,172.00	28.63	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part II | Date/Time Prepared: 8/31/2018 12:02 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.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	667,570	0	667,570	35,438.00	18.84	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	456,799	0	456,799	34,734.00	13.15	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,181,313	-479,083	702,230	39,227.00	17.90	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	479,083	479,083	33,309.00	14.38	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,701,766	109,406	1,811,172	43,220.00	41.91	38.00
39.00	Central Services and Supply	14.00	402,691	0	402,691	22,143.00	18.19	39.00
40.00	Pharmacy	15.00	1,605,950	0	1,605,950	32,709.00	49.10	40.00
41.00	Medical Records & Medical Records Library	16.00	317,600	0	317,600	18,182.00	17.47	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 8/31/2018 12:02 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		35,891,840	0	35,891,840	1,234,213.00	29.08	1.00
2.00	Excluded area salaries (see instructions)		2,345	547,762	550,107	16,276.00	33.80	2.00
3.00	Subtotal salaries (line 1 minus line 2)		35,889,495	-547,762	35,341,733	1,217,937.00	29.02	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,980,678	0	3,980,678	105,268.00	37.81	4.00
5.00	Subtotal wage-related costs (see inst.)		8,063,093	0	8,063,093	0.00	22.81	5.00
6.00	Total (sum of lines 3 thru 5)		47,933,266	-547,762	47,385,504	1,323,205.00	35.81	6.00
7.00	Total overhead cost (see instructions)		11,632,895	-549,112	11,083,783	421,219.00	26.31	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 8/31/2018 12:02 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	659,101	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	4,373,571	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	11,456	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	22,898	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-2,124	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	3,341	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	286,695	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,029,044	17.00
18.00	Medicare Taxes - Employers Portion Only	474,535	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	122,733	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,981,250	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER BENEFITS, RELOCATION EXPENSES,	200,655	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part V | Date/Time Prepared: 8/31/2018 12:02 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	393,115	7,981,250	1.00
2.00	Hospital	393,115	7,981,250	2.00
3.00	Subprovider - IPF	0	0	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	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-10 | Date/Time Prepared: 8/31/2018 12:02 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.145520	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	14,911,348	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	104,464,358	6.00
7.00	Medicaid cost (line 1 times line 6)	15,201,653	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)	290,305	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)	13,293	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	153,106	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	22,280	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)	8,987	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)	299,292	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)	4,318,610	10,766	4,329,376	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	628,444	10,766	639,210	21.00
22.00	Payments received from patients for amounts previously written off as charity care	675	0	675	22.00
23.00	Cost of charity care (line 21 minus line 22)	627,769	10,766	638,535	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)	1,978,256	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	164,264	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	252,713	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,725,543	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	339,550	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	978,085	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,277,377	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A | Date/Time Prepared: 8/31/2018 12:02 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,474,860	1,474,860	1,330,117	2,804,977	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,058,042	4,058,042	2,401,508	6,459,550	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	198,096	180,172	378,268	5,671,197	6,049,465	4.00
5.01	00570	ADMITTING	0	0	0	2,439,084	2,439,084	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	1,968,663	1,968,663	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	5,101,110	38,308,557	43,409,667	-13,097,793	30,311,874	5.03
7.00	00700	OPERATION OF PLANT	667,570	3,135,825	3,803,395	253,896	4,057,291	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	400,218	400,218	0	400,218	8.00
9.00	00900	HOUSEKEEPING	456,799	520,101	976,900	0	976,900	9.00
10.00	01000	DIETARY	1,181,313	1,070,168	2,251,481	-1,081,436	1,170,045	10.00
11.00	01100	CAFETERIA	0	0	0	1,077,374	1,077,374	11.00
13.00	01300	NURSING ADMINISTRATION	1,701,766	199,530	1,901,296	107,371	2,008,667	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	402,691	12,621,040	13,023,731	-11,301,880	1,721,851	14.00
15.00	01500	PHARMACY	1,605,950	5,013,922	6,619,872	-4,777,288	1,842,584	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	317,600	689,817	1,007,417	-15,634	991,783	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,966,634	1,948,756	9,915,390	-3,110,612	6,804,778	30.00
31.00	03100	INTENSIVE CARE UNIT	1,092,078	238,775	1,330,853	-1,203	1,329,650	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	2,730,662	766,063	3,496,725	-7,649	3,489,076	31.01
40.00	04000	SUBPROVIDER - IPF	94	7	101	-101	0	40.00
43.00	04300	NURSERY	104	141,580	141,684	1,288,807	1,430,491	43.00
44.00	04400	SKILLED NURSING FACILITY	-1,025	65	-960	960	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,289,947	4,577,884	7,867,831	1,743,127	9,610,958	50.00
51.00	05100	RECOVERY ROOM	1,891,611	574,838	2,466,449	-2,466,449	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,449	874,275	876,724	1,796,664	2,673,388	52.00
53.00	05300	ANESTHESIOLOGY	0	1,984,599	1,984,599	-185	1,984,414	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,843,441	982,875	2,826,316	-286,378	2,539,938	54.00
54.01	05401	ULTRA SOUND	389,903	32,835	422,738	0	422,738	54.01
56.00	05600	RADIOISOTOPE	78,439	136,419	214,858	-3,150	211,708	56.00
57.00	05700	CT SCAN	0	67,567	67,567	-67,567	0	57.00
58.00	05800	MRI	195,306	33,650	228,956	-1,440	227,516	58.00
60.00	06000	LABORATORY	1,560,523	1,480,402	3,040,925	-112,067	2,928,858	60.00
65.00	06500	RESPIRATORY THERAPY	991,116	342,612	1,333,728	-1,038	1,332,690	65.00
66.00	06600	PHYSICAL THERAPY	144,143	11,169	155,312	179,840	335,152	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,036	7,689	106,725	-106,725	0	67.00
68.00	06800	SPEECH PATHOLOGY	66,378	6,737	73,115	-73,115	0	68.00
69.00	06900	ELECTROCARDIOLOGY	17,049	2,455	19,504	-421	19,083	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,941,891	1,941,891	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,075,671	9,075,671	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,640,385	4,640,385	73.00
74.00	07400	RENAL DIALYSIS	0	122,292	122,292	0	122,292	74.00
76.00	03950	SLEEP LAB	194,681	1,431,274	1,625,955	-14,013	1,611,942	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	349,516	92,596	442,112	-900	441,212	90.00
91.00	09100	EMERGENCY	1,353,584	933,747	2,287,331	123,421	2,410,752	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,281	123,691	125,972	-125,972	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,890,845	84,587,104	120,477,949	-613,040	119,864,909	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,123	3,123	-2	3,121	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	995	31,432	32,427	-1,800	30,627	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	0	0	614,842	614,842	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	35,891,840	84,621,659	120,513,499	0	120,513,499	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A | Date/Time Prepared: 8/31/2018 12:02 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	438,288	3,243,265		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-116,366	6,343,184		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-7,988	6,041,477		4.00
5.01	00570	ADMITTING	0	2,439,084		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	-629,177	1,339,486		5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-13,900,273	16,411,601		5.03
7.00	00700	OPERATION OF PLANT	-26,046	4,031,245		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	98,281	498,499		8.00
9.00	00900	HOUSEKEEPING	0	976,900		9.00
10.00	01000	DIETARY	0	1,170,045		10.00
11.00	01100	CAFETERIA	-384,149	693,225		11.00
13.00	01300	NURSING ADMINISTRATION	-7,249	2,001,418		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,721,851		14.00
15.00	01500	PHARMACY	0	1,842,584		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,514	977,269		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-683,810	6,120,968		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,329,650		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	-81,000	3,408,076		31.01
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
43.00	04300	NURSERY	0	1,430,491		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	9,610,958		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-399,996	2,273,392		52.00
53.00	05300	ANESTHESIOLOGY	-1,984,414	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,000	2,538,938		54.00
54.01	05401	ULTRA SOUND	0	422,738		54.01
56.00	05600	RADIOISOTOPE	0	211,708		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	227,516		58.00
60.00	06000	LABORATORY	0	2,928,858		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,332,690		65.00
66.00	06600	PHYSICAL THERAPY	0	335,152		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	19,083		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,941,891		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,075,671		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,640,385		73.00
74.00	07400	RENAL DIALYSIS	0	122,292		74.00
76.00	03950	SLEEP LAB	-1,370,049	241,893		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	441,212		90.00
91.00	09100	EMERGENCY	-355,104	2,055,648		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-19,424,566	100,440,343		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,121		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	30,627		192.00
194.00	07950	MARKETING	0	0		194.00
194.01	07951	PHYSICIAN RELATIONS	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0		194.02
194.03	07953	WOMENS RESOURCE CENTER	0	614,842		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-19,424,566	101,088,933		200.00

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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFIT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,671,371		1.00
	TOTALS		0	5,671,371		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	343		1.00
	TOTALS		0	343		
	C - RENTAL AND LEASE EXPENSES					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,397,219		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
	TOTALS		0	2,397,219		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	79,727		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,250,390		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,289		3.00
	TOTALS		0	1,334,406		
	F - CNO SALARIES					
1.00	NURSING ADMINISTRATION	13.00	109,406	0		1.00
	TOTALS		109,406	0		
	G - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,941,548		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,075,671		2.00
	TOTALS		0	11,017,219		
	H - DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,640,385		1.00
	TOTALS		0	4,640,385		
	I - MISCELLANEOUS					
1.00	ADMITTING	5.01	2,163,909	275,175		1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.02	0	1,968,663		2.00
	TOTALS		2,163,909	2,243,838		
	J - RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	67,567		1.00
	TOTALS		0	67,567		
	K - DIETARY					
1.00	CAFETERIA	11.00	479,083	598,291		1.00
	TOTALS		479,083	598,291		
	L - MISC DEPT RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	169		1.00
2.00	OPERATING ROOM	50.00	1,891,611	575,024		2.00
3.00	PHYSICAL THERAPY	66.00	165,414	14,426		3.00
4.00	SKILLED NURSING FACILITY	44.00	1,025	0		4.00
5.00	EMERGENCY	91.00	2,281	123,594		5.00
6.00	WOMENS RESOURCE CENTER	194.03	549,112	65,730		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
	TOTALS		2,609,443	778,943		
	M - LABOR & DELIVERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	0	22,254		1.00
2.00	NURSERY	43.00	1,084,073	204,765		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	2,023,683	0		3.00
	TOTALS		3,107,756	227,019		
	N - REPAIRS & MAINTENANCE					
1.00	OPERATION OF PLANT	7.00	0	253,896		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00

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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
	TOTALS		0	253,896		
500.00	Grand Total: Increases		8,469,597	29,230,497		500.00

RECLASSIFICATIONS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-6 | Date/Time Prepared: 8/31/2018 12:02 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFIT RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	5,671,371	0		1.00
	TOTALS		0	5,671,371			
	B - OXYGEN COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	343	0		1.00
	TOTALS		0	343			
	C - RENTAL AND LEASE EXPENSES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	174	10		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	917,737	0		2.00
3.00	DIETARY	10.00	0	3,735	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	1,882	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	300,100	0		5.00
6.00	PHARMACY	15.00	0	136,903	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	15,634	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	21,744	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	55	0		9.00
10.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	4,762	0		10.00
11.00	OPERATING ROOM	50.00	0	540,875	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	335,607	0		12.00
13.00	LABORATORY	60.00	0	103,747	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	144	0		14.00
15.00	SLEEP LAB	76.00	0	14,007	0		15.00
16.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	2	0		16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	111	0		17.00
	TOTALS		0	2,397,219			
	D - OTHER CAPITAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	1,334,406	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	1,334,406			
	F - CNO SALARIES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	109,406	0	0		1.00
	TOTALS		109,406	0			
	G - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	10,957,908	0		1.00
2.00	OPERATING ROOM	50.00	0	59,311	0		2.00
	TOTALS		0	11,017,219			
	H - DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	4,640,385	0		1.00
	TOTALS		0	4,640,385			
	I - MISCELLANEOUS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	2,163,909	2,243,838	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		2,163,909	2,243,838			
	J - RADIOLOGY COSTS						
1.00	CT SCAN	57.00	0	67,567	0		1.00
	TOTALS		0	67,567			
	K - DIETARY						
1.00	DIETARY	10.00	479,083	598,291	0		1.00
	TOTALS		479,083	598,291			
	L - MISC DEPT RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	549,112	65,731	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	931	0	0		2.00
3.00	SUBPROVIDER - IPF	40.00	94	7	0		3.00
4.00	SKILLED NURSING FACILITY	44.00	0	65	0		4.00
5.00	RECOVERY ROOM	51.00	1,891,611	574,838	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	185	0		6.00
7.00	OCCUPATIONAL THERAPY	67.00	99,036	7,689	0		7.00
8.00	SPEECH PATHOLOGY	68.00	66,378	6,737	0		8.00
9.00	AMBULANCE SERVICES	95.00	2,281	123,691	0		9.00
	TOTALS		2,609,443	778,943			
	M - LABOR & DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	3,107,756	0	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	227,019	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		3,107,756	227,019			

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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	N - REPAIRS & MAINTENANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	42,283	0		1.00
2.00	DIETARY	10.00	0	327	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	153	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	43,529	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	2,604	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	1,148	0		6.00
7.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	2,887	0		7.00
8.00	NURSERY	43.00	0	31	0		8.00
9.00	OPERATING ROOM	50.00	0	123,322	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,338	0		10.00
11.00	RADIOISOTOPE	56.00	0	3,150	0		11.00
12.00	MRI	58.00	0	1,440	0		12.00
13.00	LABORATORY	60.00	0	8,320	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	894	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	421	0		15.00
16.00	SLEEP LAB	76.00	0	6	0		16.00
17.00	CLINIC	90.00	0	900	0		17.00
18.00	EMERGENCY	91.00	0	2,454	0		18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,689	0		19.00
	TOTALS		0	253,896			
500.00	Grand Total: Decreases		8,469,597	29,230,497			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-7 Part I Date/Time Prepared: 8/31/2018 12:02 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,732,541	0	0	0	0	1.00
2.00	Land Improvements	468,977	0	0	0	0	2.00
3.00	Buildings and Fixtures	55,761,046	3,047	0	3,047	0	3.00
4.00	Building Improvements	4,638,896	2,569,807	0	2,569,807	0	4.00
5.00	Fixed Equipment	3,909,841	207,106	0	207,106	297,577	5.00
6.00	Movable Equipment	57,859,182	4,566,774	0	4,566,774	1,760,734	6.00
7.00	HIT designated Assets	379,739	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	124,750,222	7,346,734	0	7,346,734	2,058,311	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	124,750,222	7,346,734	0	7,346,734	2,058,311	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,732,541	0	1.00
2.00	Land Improvements	468,977	0	2.00
3.00	Buildings and Fixtures	55,764,093	0	3.00
4.00	Building Improvements	7,208,703	0	4.00
5.00	Fixed Equipment	3,819,370	0	5.00
6.00	Movable Equipment	60,665,222	0	6.00
7.00	HIT designated Assets	379,739	0	7.00
8.00	Subtotal (sum of lines 1-7)	130,038,645	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	130,038,645	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 8/31/2018 12:02 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	1,474,860	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,058,042	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,532,902	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	1,474,860		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,058,042		2.00
3.00	Total (sum of lines 1-2)	0	5,532,902		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 8/31/2018 12:02 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	65,243,751	0	65,243,751	0.501726	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	64,794,894	0	64,794,894	0.498274	0	2.00
3.00	Total (sum of lines 1-2)	130,038,645	0	130,038,645	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,047,730	-89,326	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,672,907	2,397,219	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,720,637	2,307,893	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	-45,256	79,727	1,250,390	0	3,243,265	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	268,769	4,289	0	0	6,343,184	2.00
3.00	Total (sum of lines 1-2)	223,513	84,016	1,250,390	0	9,586,449	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8 | Date/Time Prepared: 8/31/2018 12:02 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)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-52,881	OTHER ADMINISTRATIVE AND GENERAL	5.03	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	-4,881,372			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	-589,535			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-384,149	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	B	-14,514	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	572,870	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-385,135	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	SILVER RECOVERY	B	-1,000	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8 | Date/Time Prepared: 8/31/2018 12:02 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	
35.00	RENTAL INCOME	B	-89,326	CAP REL COSTS-BLDG & FIXT	1.00	10	35.00
36.00	MISC INCOME	B	-218,583	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	36.00
38.00	TRAINING REVENUE	B	-250	NURSING ADMINISTRATION	13.00	0	38.00
39.00	PATIENT PHONE BENEFITS COST	A	-7,988	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
40.00	PHOTO COMMISSION	B	-4,082	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	40.00
41.00	PATIENT TV EXPENSE	A	-26,046	OPERATION OF PLANT	7.00	0	41.00
42.00	MARKETING EXPENSE	A	-5,171	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	42.00
42.01	MARKETING DEPARTMENT	A	-899,627	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	42.01
43.00	MINORITY INTEREST	A	-11,328,257	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	43.00
44.00	PHYSICIAN RECRUITING	A	-510,341	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	44.00
45.00	LOBBYING EXPENSE	A	-5,686	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.00
45.01	CHARITABLE CONTRIBUTIONS	A	-90,830	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.01
45.02	MEALS & ENTERTAINMENT	A	-9,878	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.02
45.03	MOB SUPPORT COSTS	A	-484,006	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.03
45.04	LEGAL FEES	A	-8,779	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-19,424,566				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: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 8/31/2018 12:02 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	5.03	OTHER ADMINISTRATIVE AND GEN	DIRECT ALLOCATION INTEREST	261,157	0	1.00
2.00	5.03	OTHER ADMINISTRATIVE AND GEN	PASI OPERATING COSTS	439,175	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS	29,824	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS	8,350	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	POOLED CAPITAL - BLDGS	47,832	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	POOLED CAPITAL - FIXTURES	298,169	0	4.02
4.03	5.03	OTHER ADMINISTRATIVE AND GEN	POOLED ADMIN COSTS	2,764,861	0	4.03
4.04	5.03	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEES	0	1,567,743	4.04
4.05	5.03	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	6,403	4.05
4.06	5.03	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	225,639	4.06
4.07	5.03	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIO	0	2,941,706	4.07
4.15	5.02	CASHIERING/ACCOUNTS RECEIVAB	PASI COLLECTION FEES	0	563,813	4.15
4.16	5.02	CASHIERING/ACCOUNTS RECEIVAB	PASI LIEN UNIT	0	65,364	4.16
4.17	5.03	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE	149,469	568,222	4.17
4.18	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY - OPERATING	323,374	225,093	4.18
4.19	1.00	CAP REL COSTS-BLDG & FIXT	LAUNDRY - CAPITAL	38,425	175,125	4.19
4.20	1.00	CAP REL COSTS-BLDG & FIXT	DSC BLDG LEASE SJH	627,201	613,413	4.20
4.22	5.03	OTHER ADMINISTRATIVE AND GEN	SHARED SERVICE ALLOCATION	1,412,899	0	4.22
4.26	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	105,729	143,479	4.26
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,506,465	7,096,000	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B	CHS, INC.	72.03	CHS, INC.	72.03	6.00
7.00	B	HOSPITAL LAUNDR	100.00	HOSPITAL LAUNDR	100.00	7.00
8.00	B	LUTHERAN HEALTH	100.00	LUTHERAN HEALTH	100.00	8.00
9.00	B	PASI	100.00	PASI	100.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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.

(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: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 8/31/2018 12:02 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	261,157	0		1.00
2.00	439,175	0		2.00
3.00	29,824	11		3.00
4.00	8,350	11		4.00
4.01	47,832	11		4.01
4.02	298,169	11		4.02
4.03	2,764,861	0		4.03
4.04	-1,567,743	0		4.04
4.05	-6,403	0		4.05
4.06	-225,639	0		4.06
4.07	-2,941,706	0		4.07
4.15	-563,813	0		4.15
4.16	-65,364	0		4.16
4.17	-418,753	0		4.17
4.18	98,281	0		4.18
4.19	-136,700	11		4.19
4.20	13,788	11		4.20
4.22	1,412,899	0		4.22
4.26	-37,750	11		4.26
5.00	-589,535			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	HOSPITAL MANAGEMENT		6.00
7.00	LAUNDRY		7.00
8.00	HOSPITAL NETWOR		8.00
9.00	DEBT COLLECTION		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: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 8/31/2018 12:02 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	13.00	NURSING ADMINISTRATION	6,999	6,999	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	683,810	683,810	0	0	0	2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	81,000	81,000	0	0	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	399,996	399,996	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	1,984,414	1,984,414	0	0	0	5.00
6.00	76.00	SLEEP LAB	1,370,049	1,370,049	0	0	0	6.00
7.00	91.00	EMERGENCY	355,104	355,104	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			4,881,372	4,881,372	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	76.00	SLEEP LAB	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	13.00	NURSING ADMINISTRATION	0	0	0	6,999		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	683,810		2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	81,000		3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	399,996		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,984,414		5.00
6.00	76.00	SLEEP LAB	0	0	0	1,370,049		6.00
7.00	91.00	EMERGENCY	0	0	0	355,104		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	4,881,372		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I Date/Time Prepared: 8/31/2018 12:02 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,243,265	3,243,265				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	6,343,184		6,343,184			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,041,477	8,377	16,384	6,066,238		4.00
5.01	00570	ADMITTING	2,439,084	0	0	367,761	2,806,845	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,339,486	0	0	0	0	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	16,411,601	109,964	215,068	387,267	0	5.03
7.00	00700	OPERATION OF PLANT	4,031,245	905,820	1,771,601	113,455	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	498,499	10,151	19,854	0	0	8.00
9.00	00900	HOUSEKEEPING	976,900	83,029	162,389	77,634	0	9.00
10.00	01000	DIETARY	1,170,045	0	0	119,345	0	10.00
11.00	01100	CAFETERIA	693,225	30,774	60,188	81,421	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,001,418	17,292	33,820	307,812	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,721,851	10,850	21,220	68,438	0	14.00
15.00	01500	PHARMACY	1,842,584	0	0	272,934	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	977,269	0	0	53,977	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,120,968	670,532	1,311,429	825,618	165,966	30.00
31.00	03100	INTENSIVE CARE UNIT	1,329,650	98,053	191,772	185,601	10,098	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	3,408,076	141,466	276,679	464,081	133,987	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	1,430,491	44,474	86,983	184,258	31,675	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,610,958	656,527	1,284,037	880,631	925,093	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,273,392	0	0	344,345	59,195	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,538,938	135,532	265,073	313,296	175,762	54.00
54.01	05401	ULTRA SOUND	422,738	0	0	66,265	56,333	54.01
56.00	05600	RADIOISOTOPE	211,708	0	0	13,331	16,123	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	227,516	0	0	33,193	37,019	58.00
60.00	06000	LABORATORY	2,928,858	25,073	49,038	265,214	213,400	60.00
65.00	06500	RESPIRATORY THERAPY	1,332,690	0	0	168,442	40,249	65.00
66.00	06600	PHYSICAL THERAPY	335,152	8,697	17,010	52,610	9,534	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	19,083	0	0	2,898	14,452	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,941,891	0	0	0	238,252	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,075,671	0	0	0	207,235	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,640,385	0	0	0	314,974	73.00
74.00	07400	RENAL DIALYSIS	122,292	0	0	0	2,726	74.00
76.00	03950	SLEEP LAB	241,893	32,519	63,602	33,086	11,095	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	441,212	0	0	59,401	11,074	90.00
91.00	09100	EMERGENCY	2,055,648	115,956	226,787	230,432	132,603	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100,440,343	3,105,086	6,072,934	5,972,746	2,806,845	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,121	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,627	8,217	16,071	169	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	614,842	129,962	254,179	93,323	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	101,088,933	3,243,265	6,343,184	6,066,238	2,806,845	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I | Date/Time Prepared: 8/31/2018 12:02 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,339,486					5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	17,123,900	17,123,900			5.03
7.00	00700	OPERATION OF PLANT	0	6,822,121	1,391,310	8,213,431		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	528,504	107,784	37,573	673,861	8.00
9.00	00900	HOUSEKEEPING	0	1,299,952	265,114	307,311	0	9.00
10.00	01000	DIETARY	0	1,289,390	262,959	0	0	10.00
11.00	01100	CAFETERIA	0	865,608	176,533	113,903	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,360,342	481,371	64,003	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,822,359	371,654	40,157	1,514	14.00
15.00	01500	PHARMACY	0	2,115,518	431,441	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,031,246	210,313	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	79,211	9,173,724	1,870,898	2,481,797	211,014	30.00
31.00	03100	INTENSIVE CARE UNIT	4,820	1,819,994	371,171	362,917	28,827	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	63,948	4,488,237	915,336	523,597	10,850	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	15,118	1,792,999	365,666	164,610	10,749	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	441,377	13,798,623	2,814,091	2,429,961	155,952	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,252	2,705,184	551,698	0	116,471	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	83,886	3,512,487	716,340	501,635	59,811	54.00
54.01	05401	ULTRA SOUND	26,886	572,222	116,700	0	0	54.01
56.00	05600	RADIOISOTOPE	7,695	248,857	50,752	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	17,668	315,396	64,322	0	0	58.00
60.00	06000	LABORATORY	101,850	3,583,433	730,809	92,802	0	60.00
65.00	06500	RESPIRATORY THERAPY	19,210	1,560,591	318,268	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,551	427,554	87,196	32,190	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	6,897	43,330	8,837	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	113,711	2,293,854	467,811	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	98,908	9,381,814	1,913,337	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	150,329	5,105,688	1,041,259	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,301	126,319	25,762	0	0	74.00
76.00	03950	SLEEP LAB	5,295	387,490	79,025	120,362	8,760	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,285	516,972	105,432	0	0	90.00
91.00	09100	EMERGENCY	63,288	2,824,714	576,075	429,181	69,913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,339,486	99,938,422	16,889,264	7,701,999	673,861	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,121	636	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	55,084	11,234	30,414	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	1,092,306	222,766	481,018	0	194.03
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,339,486	101,088,933	17,123,900	8,213,431	673,861	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I | Date/Time Prepared: 8/31/2018 12:02 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	1,872,377					9.00
10.00	01000	DIETARY	0	1,552,349				10.00
11.00	01100	CAFETERIA	27,104	0	1,183,148			11.00
13.00	01300	NURSING ADMINISTRATION	15,230	0	54,762	2,975,708		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,556	0	28,066	0	2,273,306	14.00
15.00	01500	PHARMACY	0	0	41,453	0	26,028	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	23,033	0	447	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	590,559	826,461	206,371	1,317,744	46,788	30.00
31.00	03100	INTENSIVE CARE UNIT	86,359	37,318	41,954	182,152	14,823	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	124,594	237,310	99,641	490,630	58,837	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	39,170	163,090	42,929	0	18,003	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	578,227	0	224,871	667,742	374,188	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	80,219	7,909	57,030	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,368	0	72,418	62,022	64,471	54.00
54.01	05401	ULTRA SOUND	0	0	14,152	0	482	54.01
56.00	05600	RADIOISOTOPE	0	0	2,978	0	13,007	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	7,405	0	2,288	58.00
60.00	06000	LABORATORY	22,083	0	83,197	0	104,186	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	39,213	0	27,195	65.00
66.00	06600	PHYSICAL THERAPY	7,660	0	8,802	0	160	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	184	0	87	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	240,478	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,171,302	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	03950	SLEEP LAB	28,641	0	11,305	0	3,649	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	11,253	38,985	8,100	90.00
91.00	09100	EMERGENCY	102,127	0	62,536	208,524	38,750	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,750,678	1,264,179	1,156,742	2,975,708	2,270,299	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,237	288,170	53	0	20	192.00
194.00	07950	MARKETING	0	0	5,798	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	114,462	0	20,555	0	2,987	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,872,377	1,552,349	1,183,148	2,975,708	2,273,306	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I Date/Time Prepared: 8/31/2018 12:02 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
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	2,614,440					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,265,039				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	74,797	16,800,153	0	16,800,153	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,551	2,950,066	0	2,950,066	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	60,385	7,009,417	0	7,009,417	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	14,275	2,611,491	0	2,611,491	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	416,976	21,460,631	0	21,460,631	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	26,678	3,545,189	0	3,545,189	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	79,212	5,187,764	0	5,187,764	54.00
54.01	05401	ULTRA SOUND	0	25,388	728,944	0	728,944	54.01
56.00	05600	RADIOISOTOPE	0	7,266	322,860	0	322,860	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	16,684	406,095	0	406,095	58.00
60.00	06000	LABORATORY	0	96,174	4,712,684	0	4,712,684	60.00
65.00	06500	RESPIRATORY THERAPY	0	18,139	1,963,406	0	1,963,406	65.00
66.00	06600	PHYSICAL THERAPY	0	4,297	567,859	0	567,859	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	6,513	58,951	0	58,951	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	107,375	3,109,518	0	3,109,518	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	93,396	12,559,849	0	12,559,849	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,614,440	141,952	8,903,339	0	8,903,339	73.00
74.00	07400	RENAL DIALYSIS	0	1,229	153,310	0	153,310	74.00
76.00	03950	SLEEP LAB	0	5,000	644,232	0	644,232	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,991	685,733	0	685,733	90.00
91.00	09100	EMERGENCY	0	59,761	4,371,581	0	4,371,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,614,440	1,265,039	98,753,072	0	98,753,072	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,757	0	3,757	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	392,212	0	392,212	192.00
194.00	07950	MARKETING	0	0	5,798	0	5,798	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	0	1,934,094	0	1,934,094	194.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,614,440	1,265,039	101,088,933	0	101,088,933	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II | Date/Time Prepared: 8/31/2018 12:02 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,377	16,384	24,761	24,761	4.00
5.01	00570	ADMITTING	0	0	0	0	1,502	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	109,964	215,068	325,032	1,581	5.03
7.00	00700	OPERATION OF PLANT	0	905,820	1,771,601	2,677,421	463	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,151	19,854	30,005	0	8.00
9.00	00900	HOUSEKEEPING	0	83,029	162,389	245,418	317	9.00
10.00	01000	DIETARY	0	0	0	0	487	10.00
11.00	01100	CAFETERIA	0	30,774	60,188	90,962	332	11.00
13.00	01300	NURSING ADMINISTRATION	0	17,292	33,820	51,112	1,257	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,850	21,220	32,070	279	14.00
15.00	01500	PHARMACY	0	0	0	0	1,115	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	220	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	670,532	1,311,429	1,981,961	3,371	30.00
31.00	03100	INTENSIVE CARE UNIT	0	98,053	191,772	289,825	758	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	141,466	276,679	418,145	1,895	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	44,474	86,983	131,457	752	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	656,527	1,284,037	1,940,564	3,587	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	1,406	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	135,532	265,073	400,605	1,279	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	271	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	54	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	136	58.00
60.00	06000	LABORATORY	0	25,073	49,038	74,111	1,083	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	688	65.00
66.00	06600	PHYSICAL THERAPY	0	8,697	17,010	25,707	215	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	12	69.00
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	03950	SLEEP LAB	0	32,519	63,602	96,121	135	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	243	90.00
91.00	09100	EMERGENCY	0	115,956	226,787	342,743	941	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,105,086	6,072,934	9,178,020	24,379	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,217	16,071	24,288	1	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	129,962	254,179	384,141	381	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,243,265	6,343,184	9,586,449	24,761	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II | Date/Time Prepared: 8/31/2018 12:02 pm

		Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		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
5.01	00570	ADMITTING	1,502					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0				5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	326,613			5.03
7.00	00700	OPERATION OF PLANT	0	0	26,538	2,704,422		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	2,056	12,372	44,433	8.00
9.00	00900	HOUSEKEEPING	0	0	5,057	101,188	0	9.00
10.00	01000	DIETARY	0	0	5,016	0	0	10.00
11.00	01100	CAFETERIA	0	0	3,367	37,505	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	9,182	21,074	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	7,089	13,222	100	14.00
15.00	01500	PHARMACY	0	0	8,229	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	4,012	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	80	0	35,686	817,177	13,913	30.00
31.00	03100	INTENSIVE CARE UNIT	5	0	7,080	119,497	1,901	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	65	0	17,459	172,404	715	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	15	0	6,975	54,201	709	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	594	0	53,665	800,109	10,283	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29	0	10,523	0	7,680	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	85	0	13,664	165,172	3,944	54.00
54.01	05401	ULTRA SOUND	27	0	2,226	0	0	54.01
56.00	05600	RADIOISOTOPE	8	0	968	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	18	0	1,227	0	0	58.00
60.00	06000	LABORATORY	103	0	13,940	30,557	0	60.00
65.00	06500	RESPIRATORY THERAPY	19	0	6,071	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5	0	1,663	10,599	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	7	0	169	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	115	0	8,923	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100	0	36,495	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	152	0	19,861	0	0	73.00
74.00	07400	RENAL DIALYSIS	1	0	491	0	0	74.00
76.00	03950	SLEEP LAB	5	0	1,507	39,631	578	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5	0	2,011	0	0	90.00
91.00	09100	EMERGENCY	64	0	10,988	141,316	4,610	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,502	0	322,138	2,536,024	44,433	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	12	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	214	10,014	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	0	4,249	158,384	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,502	0	326,613	2,704,422	44,433	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II | Date/Time Prepared: 8/31/2018 12:02 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	351,980					9.00
10.00	01000	DIETARY	0	5,503				10.00
11.00	01100	CAFETERIA	5,095	0	137,261			11.00
13.00	01300	NURSING ADMINISTRATION	2,863	0	6,353	91,841		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,796	0	3,256	0	57,812	14.00
15.00	01500	PHARMACY	0	0	4,809	0	662	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	2,672	0	11	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	111,020	2,930	23,942	40,670	1,190	30.00
31.00	03100	INTENSIVE CARE UNIT	16,234	132	4,867	5,622	377	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	23,422	841	11,560	15,143	1,496	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	7,363	578	4,980	0	458	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	108,698	0	26,090	20,609	9,516	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	9,306	244	1,450	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,439	0	8,401	1,914	1,640	54.00
54.01	05401	ULTRA SOUND	0	0	1,642	0	12	54.01
56.00	05600	RADIOISOTOPE	0	0	345	0	331	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	859	0	58	58.00
60.00	06000	LABORATORY	4,151	0	9,652	0	2,650	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	4,549	0	692	65.00
66.00	06600	PHYSICAL THERAPY	1,440	0	1,021	0	4	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	21	0	2	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	6,116	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	29,785	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	03950	SLEEP LAB	5,384	0	1,312	0	93	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	1,305	1,203	206	90.00
91.00	09100	EMERGENCY	19,198	0	7,255	6,436	986	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	329,103	4,481	134,197	91,841	57,735	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,360	1,022	6	0	1	192.00
194.00	07950	MARKETING	0	0	673	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	21,517	0	2,385	0	76	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	351,980	5,503	137,261	91,841	57,812	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II | Date/Time Prepared: 8/31/2018 12:02 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
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	14,815					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,915				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	401	3,032,341	0	3,032,341	30.00
31.00	03100	INTENSIVE CARE UNIT	0	24	446,322	0	446,322	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	324	663,469	0	663,469	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	77	207,565	0	207,565	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,364	2,976,079	0	2,976,079	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	143	30,781	0	30,781	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	425	619,568	0	619,568	54.00
54.01	05401	ULTRA SOUND	0	136	4,314	0	4,314	54.01
56.00	05600	RADIOISOTOPE	0	39	1,745	0	1,745	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	90	2,388	0	2,388	58.00
60.00	06000	LABORATORY	0	516	136,763	0	136,763	60.00
65.00	06500	RESPIRATORY THERAPY	0	97	12,116	0	12,116	65.00
66.00	06600	PHYSICAL THERAPY	0	23	40,677	0	40,677	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	35	246	0	246	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	576	15,730	0	15,730	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	501	66,881	0	66,881	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,815	762	35,590	0	35,590	73.00
74.00	07400	RENAL DIALYSIS	0	7	499	0	499	74.00
76.00	03950	SLEEP LAB	0	27	144,793	0	144,793	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	27	5,000	0	5,000	90.00
91.00	09100	EMERGENCY	0	321	534,858	0	534,858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,815	6,915	8,977,725	0	8,977,725	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	12	0	12	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	36,906	0	36,906	192.00
194.00	07950	MARKETING	0	0	673	0	673	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	0	571,133	0	571,133	194.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,815	6,915	9,586,449	0	9,586,449	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/31/2018 12:02 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	223,003					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		223,003				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	576	576	35,693,744			4.00
5.01	00570	ADMITTING	0	0	2,163,909	678,619,787		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	678,619,787	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	7,561	7,561	2,278,683	0	0	5.03
7.00	00700	OPERATION OF PLANT	62,283	62,283	667,570	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	698	698	0	0	0	8.00
9.00	00900	HOUSEKEEPING	5,709	5,709	456,799	0	0	9.00
10.00	01000	DIETARY	0	0	702,230	0	0	10.00
11.00	01100	CAFETERIA	2,116	2,116	479,083	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,189	1,189	1,811,172	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	746	746	402,691	0	0	14.00
15.00	01500	PHARMACY	0	0	1,605,950	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	317,600	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,105	46,105	4,857,947	40,127,178	40,127,178	30.00
31.00	03100	INTENSIVE CARE UNIT	6,742	6,742	1,092,078	2,441,561	2,441,561	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	9,727	9,727	2,730,662	32,395,193	32,395,193	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	3,058	3,058	1,084,177	7,658,426	7,658,426	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,142	45,142	5,181,558	223,650,306	223,650,306	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	2,026,132	14,312,206	14,312,206	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,319	9,319	1,843,441	42,495,619	42,495,619	54.00
54.01	05401	ULTRA SOUND	0	0	389,903	13,620,225	13,620,225	54.01
56.00	05600	RADIOISOTOPE	0	0	78,439	3,898,303	3,898,303	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	195,306	8,950,393	8,950,393	58.00
60.00	06000	LABORATORY	1,724	1,724	1,560,523	51,595,645	51,595,645	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	991,116	9,731,420	9,731,420	65.00
66.00	06600	PHYSICAL THERAPY	598	598	309,557	2,305,244	2,305,244	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	17,049	3,494,163	3,494,163	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	57,604,452	57,604,452	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	50,105,271	50,105,271	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	76,154,376	76,154,376	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	659,156	659,156	74.00
76.00	03950	SLEEP LAB	2,236	2,236	194,681	2,682,555	2,682,555	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	349,516	2,677,383	2,677,383	90.00
91.00	09100	EMERGENCY	7,973	7,973	1,355,865	32,060,712	32,060,712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	213,502	213,502	35,143,637	678,619,787	678,619,787	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	565	565	995	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	8,936	8,936	549,112	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,243,265	6,343,184	6,066,238	2,806,845	1,339,486	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.543594	28.444389	0.169952	0.004136	0.001974	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			24,761	1,502	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000694	0.000002	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/31/2018 12:02 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
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: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/31/2018 12:02 pm

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.03	5.03	7.00	8.00	9.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-17,123,900	83,965,033				5.03
7.00	00700	OPERATION OF PLANT	0	6,822,121	152,583			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	528,504	698	555,178		8.00
9.00	00900	HOUSEKEEPING	0	1,299,952	5,709	0	146,176	9.00
10.00	01000	DIETARY	0	1,289,390	0	0	0	10.00
11.00	01100	CAFETERIA	0	865,608	2,116	0	2,116	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,360,342	1,189	0	1,189	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,822,359	746	1,247	746	14.00
15.00	01500	PHARMACY	0	2,115,518	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,031,246	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	9,173,724	46,105	173,849	46,105	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,819,994	6,742	23,750	6,742	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	4,488,237	9,727	8,939	9,727	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	1,792,999	3,058	8,856	3,058	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,798,623	45,142	128,485	45,142	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,705,184	0	95,958	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,512,487	9,319	49,277	9,319	54.00
54.01	05401	ULTRA SOUND	0	572,222	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	248,857	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	315,396	0	0	0	58.00
60.00	06000	LABORATORY	0	3,583,433	1,724	0	1,724	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,560,591	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	427,554	598	0	598	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	43,330	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,293,854	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,381,814	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,105,688	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	126,319	0	0	0	74.00
76.00	03950	SLEEP LAB	0	387,490	2,236	7,217	2,236	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	516,972	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,824,714	7,973	57,600	7,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-17,123,900	82,814,522	143,082	555,178	136,675	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,121	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	55,084	565	0	565	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	1,092,306	8,936	0	8,936	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		17,123,900	8,213,431	673,861	1,872,377	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.203941	53.829267	1.213775	12.809059	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		326,613	2,704,422	44,433	351,980	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.003890	17.724268	0.080034	2.407919	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: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/31/2018 12:02 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
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	123,339					10.00
11.00	01100	CAFETERIA	0	44,896				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,078	16,973,196			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,065	0	17,745,562		14.00
15.00	01500	PHARMACY	0	1,573	0	203,175	4,640,385	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	874	0	3,490	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,665	7,831	7,516,299	365,228	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,965	1,592	1,038,980	115,707	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	18,855	3,781	2,798,517	459,283	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	12,958	1,629	0	140,533	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,533	3,808,750	2,920,924	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,044	45,112	445,178	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,748	353,766	503,265	0	54.00
54.01	05401	ULTRA SOUND	0	537	0	3,763	0	54.01
56.00	05600	RADIOISOTOPE	0	113	0	101,537	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	281	0	17,860	0	58.00
60.00	06000	LABORATORY	0	3,157	0	813,282	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,488	0	212,285	0	65.00
66.00	06600	PHYSICAL THERAPY	0	334	0	1,249	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	7	0	677	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,877,183	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,143,263	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,640,385	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0	429	0	28,487	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	427	222,367	63,229	0	90.00
91.00	09100	EMERGENCY	0	2,373	1,189,405	302,487	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100,443	43,894	16,973,196	17,722,085	4,640,385	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,896	2	0	158	0	192.00
194.00	07950	MARKETING	0	220	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	780	0	23,319	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,552,349	1,183,148	2,975,708	2,273,306	2,614,440	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.586035	26.353083	0.175318	0.128106	0.563410	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,503	137,261	91,841	57,812	14,815	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.044617	3.057310	0.005411	0.003258	0.003193	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/31/2018 12:02 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/31/2018 12:02 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL			5.03
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	678,619,787		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	40,127,178		30.00
31.00	03100	INTENSIVE CARE UNIT	2,441,561		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	32,395,193		31.01
40.00	04000	SUBPROVIDER - IPF	0		40.00
43.00	04300	NURSERY	7,658,426		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	223,650,306		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,312,206		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,495,619		54.00
54.01	05401	ULTRA SOUND	13,620,225		54.01
56.00	05600	RADIOISOTOPE	3,898,303		56.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MRI	8,950,393		58.00
60.00	06000	LABORATORY	51,595,645		60.00
65.00	06500	RESPIRATORY THERAPY	9,731,420		65.00
66.00	06600	PHYSICAL THERAPY	2,305,244		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	3,494,163		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	57,604,452		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	50,105,271		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,154,376		73.00
74.00	07400	RENAL DIALYSIS	659,156		74.00
76.00	03950	SLEEP LAB	2,682,555		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	2,677,383		90.00
91.00	09100	EMERGENCY	32,060,712		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	678,619,787		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	MARKETING	0		194.00
194.01	07951	PHYSICIAN RELATIONS	0		194.01
194.02	07952	SENIOR CIRCLE	0		194.02
194.03	07953	WOMENS RESOURCE CENTER	0		194.03
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,265,039		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001864		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,915		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000010		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/31/2018 12:02 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			16.00		
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/31/2018 12:02 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	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,800,153		16,800,153	0	16,800,153	30.00
31.00	03100	INTENSIVE CARE UNIT	2,950,066		2,950,066	0	2,950,066	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	7,009,417		7,009,417	0	7,009,417	31.01
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	2,611,491		2,611,491	0	2,611,491	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,460,631		21,460,631	0	21,460,631	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,545,189		3,545,189	0	3,545,189	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,187,764		5,187,764	0	5,187,764	54.00
54.01	05401	ULTRA SOUND	728,944		728,944	0	728,944	54.01
56.00	05600	RADIOISOTOPE	322,860		322,860	0	322,860	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	406,095		406,095	0	406,095	58.00
60.00	06000	LABORATORY	4,712,684		4,712,684	0	4,712,684	60.00
65.00	06500	RESPIRATORY THERAPY	1,963,406	0	1,963,406	0	1,963,406	65.00
66.00	06600	PHYSICAL THERAPY	567,859	0	567,859	0	567,859	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	58,951		58,951	0	58,951	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,109,518		3,109,518	0	3,109,518	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,559,849		12,559,849	0	12,559,849	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,903,339		8,903,339	0	8,903,339	73.00
74.00	07400	RENAL DIALYSIS	153,310		153,310	0	153,310	74.00
76.00	03950	SLEEP LAB	644,232		644,232	0	644,232	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	685,733		685,733	0	685,733	90.00
91.00	09100	EMERGENCY	4,371,581		4,371,581	0	4,371,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,144,358		3,144,358		3,144,358	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	101,897,430	0	101,897,430	0	101,897,430	200.00
201.00		Less Observation Beds	3,144,358		3,144,358		3,144,358	201.00
202.00		Total (see instructions)	98,753,072	0	98,753,072	0	98,753,072	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/31/2018 12:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,316,020		26,316,020			30.00
31.00	03100	INTENSIVE CARE UNIT	2,441,561		2,441,561			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	32,395,193		32,395,193			31.01
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	7,658,426		7,658,426			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,493,577	183,156,729	223,650,306	0.095956	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,312,206	0	14,312,206	0.247704	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,042,708	36,452,911	42,495,619	0.122078	0.000000	54.00
54.01	05401	ULTRA SOUND	2,871,843	10,748,382	13,620,225	0.053519	0.000000	54.01
56.00	05600	RADIOISOTOPE	243,171	3,655,132	3,898,303	0.082821	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	536,803	8,413,590	8,950,393	0.045372	0.000000	58.00
60.00	06000	LABORATORY	21,559,363	30,036,282	51,595,645	0.091339	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,432,834	1,298,586	9,731,420	0.201759	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,009,405	295,839	2,305,244	0.246334	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	802,407	2,691,756	3,494,163	0.016871	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,636,271	44,968,181	57,604,452	0.053981	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,731,544	37,373,727	50,105,271	0.250669	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,699,632	42,454,744	76,154,376	0.116912	0.000000	73.00
74.00	07400	RENAL DIALYSIS	592,078	67,078	659,156	0.232585	0.000000	74.00
76.00	03950	SLEEP LAB	38,500	2,644,055	2,682,555	0.240156	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	28,874	2,648,509	2,677,383	0.256121	0.000000	90.00
91.00	09100	EMERGENCY	4,595,849	27,464,863	32,060,712	0.136353	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,043,975	12,767,183	13,811,158	0.227668	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	231,482,240	447,137,547	678,619,787			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	231,482,240	447,137,547	678,619,787			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/31/2018 12:02 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
31.01	03101	NEONATAL INTENSIVE CARE UNIT		31.01
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.095956	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.247704	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122078	54.00
54.01	05401	ULTRA SOUND	0.053519	54.01
56.00	05600	RADIOISOTOPE	0.082821	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.045372	58.00
60.00	06000	LABORATORY	0.091339	60.00
65.00	06500	RESPIRATORY THERAPY	0.201759	65.00
66.00	06600	PHYSICAL THERAPY	0.246334	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.016871	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.053981	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.250669	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.116912	73.00
74.00	07400	RENAL DIALYSIS	0.232585	74.00
76.00	03950	SLEEP LAB	0.240156	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.256121	90.00
91.00	09100	EMERGENCY	0.136353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.227668	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/31/2018 12:02 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	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,800,153		16,800,153	0	16,800,153	30.00
31.00	03100	INTENSIVE CARE UNIT	2,950,066		2,950,066	0	2,950,066	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	7,009,417		7,009,417	0	7,009,417	31.01
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	2,611,491		2,611,491	0	2,611,491	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,460,631		21,460,631	0	21,460,631	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,545,189		3,545,189	0	3,545,189	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,187,764		5,187,764	0	5,187,764	54.00
54.01	05401	ULTRA SOUND	728,944		728,944	0	728,944	54.01
56.00	05600	RADIOISOTOPE	322,860		322,860	0	322,860	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	406,095		406,095	0	406,095	58.00
60.00	06000	LABORATORY	4,712,684		4,712,684	0	4,712,684	60.00
65.00	06500	RESPIRATORY THERAPY	1,963,406	0	1,963,406	0	1,963,406	65.00
66.00	06600	PHYSICAL THERAPY	567,859	0	567,859	0	567,859	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	58,951		58,951	0	58,951	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,109,518		3,109,518	0	3,109,518	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,559,849		12,559,849	0	12,559,849	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,903,339		8,903,339	0	8,903,339	73.00
74.00	07400	RENAL DIALYSIS	153,310		153,310	0	153,310	74.00
76.00	03950	SLEEP LAB	644,232		644,232	0	644,232	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	685,733		685,733	0	685,733	90.00
91.00	09100	EMERGENCY	4,371,581		4,371,581	0	4,371,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,144,358		3,144,358		3,144,358	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	101,897,430	0	101,897,430	0	101,897,430	200.00
201.00		Less Observation Beds	3,144,358		3,144,358		3,144,358	201.00
202.00		Total (see instructions)	98,753,072	0	98,753,072	0	98,753,072	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/31/2018 12:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,316,020		26,316,020			30.00
31.00	03100	INTENSIVE CARE UNIT	2,441,561		2,441,561			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	32,395,193		32,395,193			31.01
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	7,658,426		7,658,426			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,493,577	183,156,729	223,650,306	0.095956	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,312,206	0	14,312,206	0.247704	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,042,708	36,452,911	42,495,619	0.122078	0.000000	54.00
54.01	05401	ULTRA SOUND	2,871,843	10,748,382	13,620,225	0.053519	0.000000	54.01
56.00	05600	RADIOISOTOPE	243,171	3,655,132	3,898,303	0.082821	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	536,803	8,413,590	8,950,393	0.045372	0.000000	58.00
60.00	06000	LABORATORY	21,559,363	30,036,282	51,595,645	0.091339	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,432,834	1,298,586	9,731,420	0.201759	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,009,405	295,839	2,305,244	0.246334	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	802,407	2,691,756	3,494,163	0.016871	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,636,271	44,968,181	57,604,452	0.053981	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,731,544	37,373,727	50,105,271	0.250669	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,699,632	42,454,744	76,154,376	0.116912	0.000000	73.00
74.00	07400	RENAL DIALYSIS	592,078	67,078	659,156	0.232585	0.000000	74.00
76.00	03950	SLEEP LAB	38,500	2,644,055	2,682,555	0.240156	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	28,874	2,648,509	2,677,383	0.256121	0.000000	90.00
91.00	09100	EMERGENCY	4,595,849	27,464,863	32,060,712	0.136353	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,043,975	12,767,183	13,811,158	0.227668	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	231,482,240	447,137,547	678,619,787			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	231,482,240	447,137,547	678,619,787			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/31/2018 12:02 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
31.01	03101	NEONATAL INTENSIVE CARE UNIT		31.01
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.095956	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.247704	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122078	54.00
54.01	05401	ULTRA SOUND	0.053519	54.01
56.00	05600	RADIOISOTOPE	0.082821	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.045372	58.00
60.00	06000	LABORATORY	0.091339	60.00
65.00	06500	RESPIRATORY THERAPY	0.201759	65.00
66.00	06600	PHYSICAL THERAPY	0.246334	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.016871	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.053981	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.250669	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.116912	73.00
74.00	07400	RENAL DIALYSIS	0.232585	74.00
76.00	03950	SLEEP LAB	0.240156	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.256121	90.00
91.00	09100	EMERGENCY	0.136353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.227668	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part II Date/Time Prepared: 8/31/2018 12:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	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	21,460,631	2,976,079	18,484,552	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,545,189	30,781	3,514,408	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,187,764	619,568	4,568,196	0	0	54.00
54.01	05401	ULTRA SOUND	728,944	4,314	724,630	0	0	54.01
56.00	05600	RADIOISOTOPE	322,860	1,745	321,115	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	406,095	2,388	403,707	0	0	58.00
60.00	06000	LABORATORY	4,712,684	136,763	4,575,921	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,963,406	12,116	1,951,290	0	0	65.00
66.00	06600	PHYSICAL THERAPY	567,859	40,677	527,182	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	58,951	246	58,705	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,109,518	15,730	3,093,788	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,559,849	66,881	12,492,968	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,903,339	35,590	8,867,749	0	0	73.00
74.00	07400	RENAL DIALYSIS	153,310	499	152,811	0	0	74.00
76.00	03950	SLEEP LAB	644,232	144,793	499,439	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	685,733	5,000	680,733	0	0	90.00
91.00	09100	EMERGENCY	4,371,581	534,858	3,836,723	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,144,358	567,541	2,576,817	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	72,526,303	5,195,569	67,330,734	0	0	200.00
201.00		Less Observation Beds	3,144,358	567,541	2,576,817	0	0	201.00
202.00		Total (line 200 minus line 201)	69,381,945	4,628,028	64,753,917	0	0	202.00

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

Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part II Date/Time Prepared: 8/31/2018 12:02 pm

Title XIX | Hospital | PPS

		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		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	21,460,631	223,650,306	0.095956		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,545,189	14,312,206	0.247704		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,187,764	42,495,619	0.122078		54.00
54.01	05401	ULTRA SOUND	728,944	13,620,225	0.053519		54.01
56.00	05600	RADIOISOTOPE	322,860	3,898,303	0.082821		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	406,095	8,950,393	0.045372		58.00
60.00	06000	LABORATORY	4,712,684	51,595,645	0.091339		60.00
65.00	06500	RESPIRATORY THERAPY	1,963,406	9,731,420	0.201759		65.00
66.00	06600	PHYSICAL THERAPY	567,859	2,305,244	0.246334		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	58,951	3,494,163	0.016871		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,109,518	57,604,452	0.053981		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,559,849	50,105,271	0.250669		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,903,339	76,154,376	0.116912		73.00
74.00	07400	RENAL DIALYSIS	153,310	659,156	0.232585		74.00
76.00	03950	SLEEP LAB	644,232	2,682,555	0.240156		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	685,733	2,677,383	0.256121		90.00
91.00	09100	EMERGENCY	4,371,581	32,060,712	0.136353		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,144,358	13,811,158	0.227668		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
200.00		Subtotal (sum of lines 50 thru 199)	72,526,303	609,808,587			200.00
201.00		Less Observation Beds	3,144,358	0			201.00
202.00		Total (line 200 minus line 201)	69,381,945	609,808,587			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part I Date/Time Prepared: 8/31/2018 12:02 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	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,032,341	0	3,032,341	12,604	240.59	30.00
31.00	INTENSIVE CARE UNIT	446,322		446,322	1,281	348.42	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	663,469		663,469	5,906	112.34	31.01
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
43.00	NURSERY	207,565		207,565	4,357	47.64	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	4,349,697		4,349,697	24,148		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	1,878	451,828	30.00
31.00	INTENSIVE CARE UNIT	210	73,168	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	0	0	31.01
40.00	SUBPROVIDER - IPF	0	0	40.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	2,088	524,996	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part II Date/Time Prepared: 8/31/2018 12:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,976,079	223,650,306	0.013307	5,558,789	73,971	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,781	14,312,206	0.002151	23,226	50	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	619,568	42,495,619	0.014580	1,949,951	28,430	54.00
54.01	05401	ULTRA SOUND	4,314	13,620,225	0.000317	764,362	242	54.01
56.00	05600	RADIOISOTOPE	1,745	3,898,303	0.000448	110,644	50	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	2,388	8,950,393	0.000267	152,500	41	58.00
60.00	06000	LABORATORY	136,763	51,595,645	0.002651	4,081,623	10,820	60.00
65.00	06500	RESPIRATORY THERAPY	12,116	9,731,420	0.001245	1,601,892	1,994	65.00
66.00	06600	PHYSICAL THERAPY	40,677	2,305,244	0.017645	545,206	9,620	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	246	3,494,163	0.000070	325,863	23	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,730	57,604,452	0.000273	2,058,560	562	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	66,881	50,105,271	0.001335	3,202,475	4,275	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,590	76,154,376	0.000467	6,728,032	3,142	73.00
74.00	07400	RENAL DIALYSIS	499	659,156	0.000757	295,415	224	74.00
76.00	03950	SLEEP LAB	144,793	2,682,555	0.053976	11,874	641	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,000	2,677,383	0.001867	11,254	21	90.00
91.00	09100	EMERGENCY	534,858	32,060,712	0.016683	1,322,337	22,061	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	567,541	13,811,158	0.041093	386,118	15,867	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	5,195,569	609,808,587		29,130,121	172,034	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part III Date/Time Prepared: 8/31/2018 12:02 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
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	12,604	0.00	1,878	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,281	0.00	210	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0	5,906	0.00	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
43.00	04300	NURSERY		0	4,357	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	24,148		2,088	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
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/31/2018 12:02 pm

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	03950	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV Date/Time Prepared: 8/31/2018 12:02 pm

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		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	223,650,306	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	14,312,206	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	42,495,619	0.000000	54.00
54.01	05401	ULTRA SOUND	0	0	0	13,620,225	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	3,898,303	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	8,950,393	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	51,595,645	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,731,420	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,305,244	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,494,163	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	57,604,452	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	50,105,271	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	76,154,376	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	659,156	0.000000	74.00
76.00	03950	SLEEP LAB	0	0	0	2,682,555	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	2,677,383	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	32,060,712	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,811,158	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	609,808,587		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/31/2018 12:02 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	5,558,789	0	31,927,555	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	23,226	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,949,951	0	6,442,832	0	54.00
54.01	05401	ULTRA SOUND	0.000000	764,362	0	1,652,152	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	110,644	0	788,911	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	152,500	0	1,547,268	0	58.00
60.00	06000	LABORATORY	0.000000	4,081,623	0	3,077,436	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,601,892	0	201,956	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	545,206	0	42,171	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	325,863	0	530,966	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,058,560	0	10,490,945	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,202,475	0	8,081,472	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,728,032	0	10,261,999	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	295,415	0	46,004	0	74.00
76.00	03950	SLEEP LAB	0.000000	11,874	0	488,938	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	11,254	0	645,560	0	90.00
91.00	09100	EMERGENCY	0.000000	1,322,337	0	2,928,940	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	386,118	0	877,320	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		29,130,121	0	80,032,425	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part V Date/Time Prepared: 8/31/2018 12:02 pm

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		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.095956	31,927,555	0	0	3,063,640	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.247704	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122078	6,442,832	0	0	786,528	54.00
54.01	05401	ULTRA SOUND	0.053519	1,652,152	0	0	88,422	54.01
56.00	05600	RADIOISOTOPE	0.082821	788,911	0	0	65,338	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.045372	1,547,268	0	0	70,203	58.00
60.00	06000	LABORATORY	0.091339	3,077,436	0	0	281,090	60.00
65.00	06500	RESPIRATORY THERAPY	0.201759	201,956	0	0	40,746	65.00
66.00	06600	PHYSICAL THERAPY	0.246334	42,171	0	0	10,388	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.016871	530,966	0	0	8,958	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.053981	10,490,945	0	0	566,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.250669	8,081,472	0	0	2,025,775	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.116912	10,261,999	0	0	1,199,751	73.00
74.00	07400	RENAL DIALYSIS	0.232585	46,004	0	0	10,700	74.00
76.00	03950	SLEEP LAB	0.240156	488,938	0	0	117,421	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.256121	645,560	0	0	165,341	90.00
91.00	09100	EMERGENCY	0.136353	2,928,940	0	0	399,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.227668	877,320	0	0	199,738	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		80,032,425	0	0	9,099,721	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		80,032,425	0	0	9,099,721	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part V Date/Time Prepared: 8/31/2018 12:02 pm

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	SLEEP LAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part I Date/Time Prepared: 8/31/2018 12:02 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,032,341	0	3,032,341	12,604	240.59	30.00
31.00	INTENSIVE CARE UNIT	446,322		446,322	1,281	348.42	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	663,469		663,469	5,906	112.34	31.01
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
43.00	NURSERY	207,565		207,565	4,357	47.64	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	4,349,697		4,349,697	24,148		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	71	17,082	30.00
31.00	INTENSIVE CARE UNIT	49	17,073	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	164	18,424	31.01
40.00	SUBPROVIDER - IPF	0	0	40.00
43.00	NURSERY	2,169	103,331	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	2,453	155,910	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part II Date/Time Prepared: 8/31/2018 12:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,976,079	223,650,306	0.013307	341,590	4,546	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,781	14,312,206	0.002151	218,488	470	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	619,568	42,495,619	0.014580	129,274	1,885	54.00
54.01	05401	ULTRA SOUND	4,314	13,620,225	0.000317	87,828	28	54.01
56.00	05600	RADIOISOTOPE	1,745	3,898,303	0.000448	3,196	1	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	2,388	8,950,393	0.000267	8,404	2	58.00
60.00	06000	LABORATORY	136,763	51,595,645	0.002651	638,831	1,694	60.00
65.00	06500	RESPIRATORY THERAPY	12,116	9,731,420	0.001245	534,457	665	65.00
66.00	06600	PHYSICAL THERAPY	40,677	2,305,244	0.017645	57,086	1,007	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	246	3,494,163	0.000070	9,878	1	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,730	57,604,452	0.000273	261,742	71	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	66,881	50,105,271	0.001335	5,781	8	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,590	76,154,376	0.000467	780,464	364	73.00
74.00	07400	RENAL DIALYSIS	499	659,156	0.000757	8,342	6	74.00
76.00	03950	SLEEP LAB	144,793	2,682,555	0.053976	1,476	80	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,000	2,677,383	0.001867	0	0	90.00
91.00	09100	EMERGENCY	534,858	32,060,712	0.016683	90,748	1,514	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	567,541	13,811,158	0.041093	12,742	524	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	5,195,569	609,808,587		3,190,327	12,866	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part III Date/Time Prepared: 8/31/2018 12:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	12,604	0.00	71	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,281	0.00	49	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0	5,906	0.00	164	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
43.00	04300	NURSERY		0	4,357	0.00	2,169	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	24,148		2,453	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
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV Date/Time Prepared: 8/31/2018 12:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	03950	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV Date/Time Prepared: 8/31/2018 12:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	223,650,306	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	14,312,206	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	42,495,619	0.000000	54.00
54.01	05401	ULTRA SOUND	0	0	0	13,620,225	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	3,898,303	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	8,950,393	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	51,595,645	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,731,420	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,305,244	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,494,163	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	57,604,452	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	50,105,271	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	76,154,376	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	659,156	0.000000	74.00
76.00	03950	SLEEP LAB	0	0	0	2,682,555	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	2,677,383	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	32,060,712	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,811,158	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	609,808,587		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/31/2018 12:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	341,590	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	218,488	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	129,274	0	0	0	54.00
54.01	05401	ULTRA SOUND	0.000000	87,828	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	3,196	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	8,404	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	638,831	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	534,457	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	57,086	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	9,878	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	261,742	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,781	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	780,464	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	8,342	0	0	0	74.00
76.00	03950	SLEEP LAB	0.000000	1,476	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	90,748	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	12,742	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		3,190,327	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part V Date/Time Prepared: 8/31/2018 12:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.095956	0	0	962,036	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.247704	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122078	0	0	323,099	0	54.00
54.01	05401	ULTRA SOUND	0.053519	0	0	79,024	0	54.01
56.00	05600	RADIOISOTOPE	0.082821	0	0	6,340	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.045372	0	0	73,319	0	58.00
60.00	06000	LABORATORY	0.091339	0	0	307,757	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.201759	0	0	7,486	0	65.00
66.00	06600	PHYSICAL THERAPY	0.246334	0	0	4,674	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.016871	0	0	24,988	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.053981	0	0	156,746	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.250669	0	0	135,380	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.116912	0	0	138,291	0	73.00
74.00	07400	RENAL DIALYSIS	0.232585	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0.240156	0	0	89,424	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.256121	0	0	1,063	0	90.00
91.00	09100	EMERGENCY	0.136353	0	0	542,093	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.227668	0	0	81,795	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	0	2,933,515	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	2,933,515	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part V Date/Time Prepared: 8/31/2018 12:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	92,313		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	39,443		54.00
54.01	05401	ULTRA SOUND	0	4,229		54.01
56.00	05600	RADIOISOTOPE	0	525		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	3,327		58.00
60.00	06000	LABORATORY	0	28,110		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,510		65.00
66.00	06600	PHYSICAL THERAPY	0	1,151		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	422		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,461		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	33,936		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,168		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	SLEEP LAB	0	21,476		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	272		90.00
91.00	09100	EMERGENCY	0	73,916		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	18,622		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	343,881		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	343,881		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-1 | Date/Time Prepared: 8/31/2018 12:02 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,604	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,604	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)	10,245	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)	1,878	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)	16,800,153	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)	16,800,153	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)	16,800,153	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)	1,332.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,503,224	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)	2,503,224	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-1 | Date/Time Prepared: 8/31/2018 12:02 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,950,066	1,281	2,302.94	210	483,617	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	7,009,417	5,906	1,186.83	0	0	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,713,124	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,699,965	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)	524,996	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	172,034	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	697,030	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,002,935	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,359	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,332.92	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,144,358	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-1 | Date/Time Prepared: 8/31/2018 12:02 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,032,341	16,800,153	0.180495	3,144,358	567,541	90.00
91.00	Nursing School cost	0	16,800,153	0.000000	3,144,358	0	91.00
92.00	Allied health cost	0	16,800,153	0.000000	3,144,358	0	92.00
93.00	All other Medical Education	0	16,800,153	0.000000	3,144,358	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-1 | Date/Time Prepared: 8/31/2018 12:02 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,604	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,604	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)	10,245	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)	71	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)	4,357	15.00
16.00	Nursery days (title V or XIX only)	2,169	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)	16,800,153	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)	16,800,153	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)	16,800,153	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)	1,332.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	94,637	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	94,637	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-1 | Date/Time Prepared: 8/31/2018 12:02 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2,611,491	4,357	599.38	2,169	1,300,055	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,950,066	1,281	2,302.94	49	112,844	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	7,009,417	5,906	1,186.83	164	194,640	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	412,830	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,115,006	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)	155,910	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	12,866	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	168,776	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,946,230	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,359	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,332.92	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,144,358	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-1 | Date/Time Prepared: 8/31/2018 12:02 pm

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,032,341	16,800,153	0.180495	3,144,358	567,541	90.00
91.00	Nursing School cost	0	16,800,153	0.000000	3,144,358	0	91.00
92.00	Allied health cost	0	16,800,153	0.000000	3,144,358	0	92.00
93.00	All other Medical Education	0	16,800,153	0.000000	3,144,358	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-3 | Date/Time Prepared: 8/31/2018 12:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,362,910		30.00
31.00	03100	INTENSIVE CARE UNIT		1,011,392		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0		31.01
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.095956	5,558,789	533,399	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.247704	23,226	5,753	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122078	1,949,951	238,046	54.00
54.01	05401	ULTRA SOUND	0.053519	764,362	40,908	54.01
56.00	05600	RADIOISOTOPE	0.082821	110,644	9,164	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.045372	152,500	6,919	58.00
60.00	06000	LABORATORY	0.091339	4,081,623	372,811	60.00
65.00	06500	RESPIRATORY THERAPY	0.201759	1,601,892	323,196	65.00
66.00	06600	PHYSICAL THERAPY	0.246334	545,206	134,303	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.016871	325,863	5,498	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.053981	2,058,560	111,123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.250669	3,202,475	802,761	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.116912	6,728,032	786,588	73.00
74.00	07400	RENAL DIALYSIS	0.232585	295,415	68,709	74.00
76.00	03950	SLEEP LAB	0.240156	11,874	2,852	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.256121	11,254	2,882	90.00
91.00	09100	EMERGENCY	0.136353	1,322,337	180,305	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.227668	386,118	87,907	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		29,130,121	3,713,124	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)		29,130,121		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-3 | Date/Time Prepared: 8/31/2018 12:02 pm

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		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		513,901		30.00
31.00	03100	INTENSIVE CARE UNIT		76,292		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		2,245,248		31.01
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		176,175		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.095956	341,590	32,778	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.247704	218,488	54,120	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122078	129,274	15,782	54.00
54.01	05401	ULTRA SOUND	0.053519	87,828	4,700	54.01
56.00	05600	RADIOISOTOPE	0.082821	3,196	265	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.045372	8,404	381	58.00
60.00	06000	LABORATORY	0.091339	638,831	58,350	60.00
65.00	06500	RESPIRATORY THERAPY	0.201759	534,457	107,832	65.00
66.00	06600	PHYSICAL THERAPY	0.246334	57,086	14,062	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.016871	9,878	167	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.053981	261,742	14,129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.250669	5,781	1,449	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.116912	780,464	91,246	73.00
74.00	07400	RENAL DIALYSIS	0.232585	8,342	1,940	74.00
76.00	03950	SLEEP LAB	0.240156	1,476	354	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.256121	0	0	90.00
91.00	09100	EMERGENCY	0.136353	90,748	12,374	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.227668	12,742	2,901	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,190,327	412,830	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)		3,190,327		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0150	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part A Date/Time Prepared: 8/31/2018 12:02 pm
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		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,218,233	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,110,281	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)	61,926	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	124.54	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.07	30.00
31.00	Percentage of Medicaid patient days (see instructions)	34.94	31.00
32.00	Sum of lines 30 and 31	40.01	32.00
33.00	Allowable disproportionate share percentage (see instructions)	22.22	33.00
34.00	Disproportionate share adjustment (see instructions)	240,449	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0150	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part A Date/Time Prepared: 8/31/2018 12:02 pm
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,018,846	1,007,408	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	510,819	502,324	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,013,143		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	5,644,032		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)		5,644,032	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		394,444	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		1,036	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		6,039,512	59.00
60.00	Primary payer payments		8,963	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,030,549	61.00
62.00	Deductibles billed to program beneficiaries		560,240	62.00
63.00	Coinsurance billed to program beneficiaries		10,199	63.00
64.00	Allowable bad debts (see instructions)		53,223	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		34,595	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		41,276	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		5,494,705	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-4,583	70.93
70.94	HRR adjustment amount (see instructions)		-2,398	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0150	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part A Date/Time Prepared: 8/31/2018 12:02 pm
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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,487,724	71.00
71.01	Sequestration adjustment (see instructions)		109,754	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		5,216,755	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)		161,215	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/31/2018 12:02 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,218,233	2,218,233		2,218,233	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,110,281		2,110,281	2,110,281	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	61,926	1,850	60,076	61,926	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2222	0.2222	0.2222		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	240,449	123,223	117,226	240,449	11.00
11.01	Uncompensated care payments	36.00	1,013,143	510,819	502,324	1,013,143	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	5,644,032	2,854,125	2,789,907	5,644,032	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,644,032	2,854,125	2,789,907	5,644,032	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	394,444	-171,972	566,416	394,444	16.00
17.00	Special add-on payments for new technologies	54.00	1,036	1,036	0	1,036	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			2,683,189	3,356,323	6,039,512	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/31/2018 12:02 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	347,522	-169,598	517,120	347,522	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	16,222	8,133	8,089	16,222	20.01
21.00	Capital DRG outlier payments	2.00	0	3,121	-3,121	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0844	0.0844	0.0844		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	30,700	-13,628	44,328	30,700	25.00
26.00	Total prospective capital payments (see instructions)	12.00	394,444	-171,972	566,416	394,444	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-4,583	12,305	-16,888	-4,583	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-2,398	-1,553	-845	-2,398	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0150	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part B Date/Time Prepared: 8/31/2018 12:02 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	9,099,721	2.00
3.00	OPPS payments	8,028,463	3.00
4.00	Outlier payment (see instructions)	157,195	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	8,185,658	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	3,032	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,419,449	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)	6,763,177	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)	6,763,177	30.00
31.00	Primary payer payments	2,410	31.00
32.00	Subtotal (line 30 minus line 31)	6,760,767	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)	199,490	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	129,669	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	162,725	36.00
37.00	Subtotal (see instructions)	6,890,436	37.00
38.00	MSP-LCC reconciliation amount from PS&R	25	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)	6,890,411	40.00
40.01	Sequestration adjustment (see instructions)	137,808	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	6,762,931	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-10,328	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: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 8/31/2018 12:02 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		5,179,355		6,625,519	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		37,400		137,412	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	0	0	3.01
3.02		0	0	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	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)		5,216,755		6,762,931	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		161,215		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		10,328	6.02
7.00	Total Medicare program liability (see instructions)		5,377,970		6,752,603	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: 15-0150	Period: From 04/01/2017 To 03/31/2018	Worksheet E-1 Part II Date/Time Prepared: 8/31/2018 12:02 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: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet E-3 Part VII | Date/Time Prepared: 8/31/2018 12:02 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		343,881	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	343,881	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	343,881	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	3,264,439		8.00
9.00	Ancillary service charges	3,190,327	2,933,515	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	6,454,766	2,933,515	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	6,454,766	2,933,515	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	6,454,766	2,589,634	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	343,881	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	343,881	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	343,881	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	343,881	36.00
37.00	ELIMINATE SETTLEMENT	0	-343,881	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet G | Date/Time Prepared: 8/31/2018 12:02 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	-236,866	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	34,327,863	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,271,246	0	0	0	6.00
7.00	Inventory	3,687,884	0	0	0	7.00
8.00	Prepaid expenses	1,376,121	0	0	0	8.00
9.00	Other current assets	-184,452	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)	34,699,304	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,060,000	0	0	0	12.00
13.00	Land improvements	629,378	0	0	0	13.00
14.00	Accumulated depreciation	-378,096	0	0	0	14.00
15.00	Buildings	63,596,178	0	0	0	15.00
16.00	Accumulated depreciation	-13,710,565	0	0	0	16.00
17.00	Leasehold improvements	6,986,469	0	0	0	17.00
18.00	Accumulated depreciation	-967,828	0	0	0	18.00
19.00	Fixed equipment	2,122,697	0	0	0	19.00
20.00	Accumulated depreciation	-1,845,874	0	0	0	20.00
21.00	Automobiles and trucks	24,168	0	0	0	21.00
22.00	Accumulated depreciation	-7,049	0	0	0	22.00
23.00	Major movable equipment	37,834,377	0	0	0	23.00
24.00	Accumulated depreciation	-29,002,933	0	0	0	24.00
25.00	Minor equipment depreciable	7,773,966	0	0	0	25.00
26.00	Accumulated depreciation	-5,952,102	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	68,162,786	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	6,451,685	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,451,685	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	109,313,775	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,416,234	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,732,185	0	0	0	38.00
39.00	Payroll taxes payable	373,305	0	0	0	39.00
40.00	Notes and loans payable (short term)	412,393	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-312,189,033	0	0	0	43.00
44.00	Other current liabilities	1,613,645	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-301,641,271	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,034,829	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	42,271,712	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	43,306,541	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-258,334,730	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	367,648,505				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	367,648,505	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	109,313,775	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet G-1 | Date/Time Prepared: 8/31/2018 12:02 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		338,407,550		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		29,239,213				2.00
3.00	Total (sum of line 1 and line 2)		367,646,763		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		367,646,763		0		11.00
12.00	ROUNDING	6		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		6		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		367,646,757		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	ROUNDING		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: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 8/31/2018 12:02 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	33,974,446		33,974,446	1.00
2.00	SUBPROVIDER - IPF	0		0	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	0		0	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)	33,974,446		33,974,446	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,441,561		2,441,561	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	32,395,193		32,395,193	11.01
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	34,836,754		34,836,754	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	68,811,200		68,811,200	17.00
18.00	Ancillary services	157,002,342	404,256,992	561,259,334	18.00
19.00	Outpatient services	5,668,698	42,880,555	48,549,253	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	231,482,240	447,137,547	678,619,787	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		120,513,499		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)		120,513,499		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2017 To 03/31/2018 | Worksheet G-3 | Date/Time Prepared: 8/31/2018 12:02 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	678,619,787	1.00
2.00	Less contractual allowances and discounts on patients' accounts	529,511,482	2.00
3.00	Net patient revenues (line 1 minus line 2)	149,108,305	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	120,513,499	4.00
5.00	Net income from service to patients (line 3 minus line 4)	28,594,806	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISCELLANEOUS REVENUE	644,407	24.00
25.00	Total other income (sum of lines 6-24)	644,407	25.00
26.00	Total (line 5 plus line 25)	29,239,213	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)	29,239,213	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0150	Period: From 04/01/2017 To 03/31/2018	Worksheet L Parts I-III Date/Time Prepared: 8/31/2018 12:02 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	347,522	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	16,222	1.01
2.00	Capital DRG outlier payments	0	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)	50.16	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	5.07	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	34.94	8.00
9.00	Sum of lines 7 and 8	40.01	9.00
10.00	Allowable disproportionate share percentage (see instructions)	8.44	10.00
11.00	Disproportionate share adjustment (see instructions)	30,700	11.00
12.00	Total prospective capital payments (see instructions)	394,444	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