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: 15-0006	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/30/2019 4:51 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2019 Time: 4:51 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 LAPORTE HOSPITAL (15-0006) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	114,399	-95,528	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	114,399	-95,528	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: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 4:51 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: STATE & MADISON STREETS	PO Box: 250			1.00
2.00	City: LAPORTE	State: IN	Zip Code: 46350-	County:	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	LAPORTE HOSPITAL	150006	43780	1	07/01/1966	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)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	926	742	0	1	3,007	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 4:51 pm

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	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	Y	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
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0006	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 4:51 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)	N		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)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0006	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 4:51 pm

			1.00	
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y	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)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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: 15-0006	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 4:51 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.	N			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:	314,022	38,676	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 4:51 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: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS	Contractor's Number: 10101	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.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	04/01/2018	06/30/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2019 4:51 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.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/16/2019	Y	04/16/2019	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

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

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	HILARY	BURTON	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-7066	HILARY_BURTON@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0006	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 4:51 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.	REVENUE MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2019 4:51 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	109	39,785	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)		109	39,785	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	20	7,300	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		129	47,085	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	41.00	0	0		0	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)		129				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		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: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2019 4:51 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)	7,380	1,086	13,222			1.00
2.00	HMO and other (see instructions)	2,159	3,007				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)	7,380	1,086	13,222			7.00
8.00	INTENSIVE CARE UNIT	1,089	98	2,890			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		485	1,449			13.00
14.00	Total (see instructions)	8,469	1,669	17,561	0.00	613.77	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	0	0	0	0.00	0.00	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			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	613.77	27.00
28.00	Observation Bed Days		0	1,345			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	1,729			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: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2019 4:51 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	1,882	914	4,517	1.00
2.00	HMO and other (see instructions)			425	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
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,882	914	4,517	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	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: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2019 4:51 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	40,038,955	0	40,038,955	1,276,634.00	31.36	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		344,318	0	344,318	1,888.00	182.37	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		259,544	0	259,544	7,753.00	33.48	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,496,911	0	2,496,911	53,804.00	46.41	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		55,869	0	55,869	323.00	172.97	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		3,825,076	0	3,825,076	121,680.00	31.44	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		9,120,744	0	9,120,744			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		58,445	0	58,445			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		27,028	0	27,028			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	413,892	0	413,892	12,443.00	33.26	26.00
27.00	Administrative & General	5.00	6,961,670	-235,352	6,726,318	216,294.00	31.10	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2019 4:51 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	1,119,395	0	1,119,395	45,271.00	24.73	30.00
31.00	Laundry & Linen Service	8.00	21,132	0	21,132	1,800.00	11.74	31.00
32.00	Housekeeping	9.00	310,674	0	310,674	21,170.00	14.68	32.00
33.00	Housekeeping under contract (see instructions)		704,527	0	704,527	28,590.00	24.64	33.00
34.00	Dietary	10.00	509,497	-297,776	211,721	11,667.00	18.15	34.00
35.00	Dietary under contract (see instructions)		845,734	0	845,734	30,766.00	27.49	35.00
36.00	Cafeteria	11.00	0	297,776	297,776	16,409.00	18.15	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,545,463	235,352	1,780,815	41,082.00	43.35	38.00
39.00	Central Services and Supply	14.00	811,203	0	811,203	45,191.00	17.95	39.00
40.00	Pharmacy	15.00	1,492,689	0	1,492,689	39,199.00	38.08	40.00
41.00	Medical Records & Medical Records Library	16.00	655,578	0	655,578	28,386.00	23.10	41.00
42.00	Social Service	17.00	632,961	0	632,961	19,015.00	33.29	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2019 4:51 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)		41,589,216	0	41,589,216	1,335,990.00	31.13	1.00
2.00	Excluded area salaries (see instructions)		259,544	0	259,544	7,753.00	33.48	2.00
3.00	Subtotal salaries (line 1 minus line 2)		41,329,672	0	41,329,672	1,328,237.00	31.12	3.00
4.00	Subtotal other wages & related costs (see inst.)		6,377,856	0	6,377,856	175,807.00	36.28	4.00
5.00	Subtotal wage-related costs (see inst.)		9,147,772	0	9,147,772	0.00	22.13	5.00
6.00	Total (sum of lines 3 thru 5)		56,855,300	0	56,855,300	1,504,044.00	37.80	6.00
7.00	Total overhead cost (see instructions)		16,024,415	0	16,024,415	557,283.00	28.75	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0006	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2019 4:51 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	768,484	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)	4,532,378	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	148,743	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	39,618	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	1,221	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	111,714	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	437,080	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	2,353,262	17.00
18.00	Medicare Taxes - Employers Portion Only	550,360	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	263,356	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)	9,206,216	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 5/30/2019 4:51 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	2,496,911	9,206,216	1.00
2.00	Hospital	2,496,911	9,206,216	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0006	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/30/2019 4:51 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)	0.223224	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	15,585,660	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	100,960,559	6.00
7.00	Medicaid cost (line 1 times line 6)	22,536,820	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	6,951,160	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	57,487	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	6,951,160	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)	4,009,339	0	4,009,339	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	894,981	0	894,981	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	894,981	0	894,981	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)	14,069,921	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	119,187	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	183,365	27.01
28.00	Non-Medicare bad debt expense (see instructions)	13,886,556	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,163,991	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,058,972	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	11,010,132	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/30/2019 4:51 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		5,375,114	5,375,114	1,284,818	6,659,932	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		8,993,748	8,993,748	807,043	9,800,791	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	413,892	339,025	752,917	6,122,583	6,875,500	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,961,670	48,518,054	55,479,724	-8,842,986	46,636,738	5.00
7.00	00700	OPERATION OF PLANT	1,119,395	3,261,580	4,380,975	3,431,707	7,812,682	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,132	390,754	411,886	0	411,886	8.00
9.00	00900	HOUSEKEEPING	310,674	1,277,386	1,588,060	-1,894	1,586,166	9.00
10.00	01000	DIETARY	509,497	1,491,821	2,001,318	-1,177,726	823,592	10.00
11.00	01100	CAFETERIA	0	0	0	1,158,348	1,158,348	11.00
13.00	01300	NURSING ADMINISTRATION	1,545,463	241,393	1,786,856	229,107	2,015,963	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	811,203	5,725,174	6,536,377	-5,488,484	1,047,893	14.00
15.00	01500	PHARMACY	1,492,689	4,847,355	6,340,044	-4,598,777	1,741,267	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	655,578	634,458	1,290,036	-2,790	1,287,246	16.00
17.00	01700	SOCIAL SERVICE	632,961	101,737	734,698	0	734,698	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,143,190	2,466,440	7,609,630	-21,091	7,588,539	30.00
31.00	03100	INTENSIVE CARE UNIT	1,941,648	923,985	2,865,633	-19,151	2,846,482	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	488,673	488,673	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,023,467	4,783,956	6,807,423	-694,651	6,112,772	50.00
51.00	05100	RECOVERY ROOM	1,166,039	98,811	1,264,850	0	1,264,850	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,868,441	320,030	2,188,471	-503,854	1,684,617	52.00
53.00	05300	ANESTHESIOLOGY	43,814	2,301,707	2,345,521	-18,004	2,327,517	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,812,967	1,048,097	2,861,064	-554,851	2,306,213	54.00
54.01	05401	ULTRASOUND	381,563	83,680	465,243	-37,760	427,483	54.01
56.00	05600	RADIOISOTOPE	210,927	253,998	464,925	-58,877	406,048	56.00
57.00	05700	CT SCAN	452,088	156,809	608,897	-56,595	552,302	57.00
58.00	05800	MRI	242,328	143,107	385,435	-90,475	294,960	58.00
60.00	06000	LABORATORY	2,210,807	3,363,031	5,573,838	-127,416	5,446,422	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	737,547	142,281	879,828	-37,535	842,293	65.00
66.00	06600	PHYSICAL THERAPY	1,780,544	371,733	2,152,277	-53,958	2,098,319	66.00
67.00	06700	OCCUPATIONAL THERAPY	457,905	152,749	610,654	-6,954	603,700	67.00
68.00	06800	SPEECH PATHOLOGY	387,297	40,902	428,199	-735	427,464	68.00
69.00	06900	ELECTROCARDIOLOGY	2,140,399	4,754,405	6,894,804	-835,224	6,059,580	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,641,256	1,641,256	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,727,468	3,727,468	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,530,533	4,530,533	73.00
74.00	07400	RENAL DIALYSIS	0	187,864	187,864	0	187,864	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	229,431	39,416	268,847	-9,492	259,355	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,142,945	3,142,945	0	3,142,945	90.00
91.00	09100	EMERGENCY	2,074,855	911,645	2,986,500	-6,800	2,979,700	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)	39,779,411	106,885,190	146,664,601	175,456	146,840,057	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	166,241	1,218,909	1,385,150	-175,456	1,209,694	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	93,303	12,387	105,690	0	105,690	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	40,038,955	108,116,486	148,155,441	0	148,155,441	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/30/2019 4:51 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	-178,615	6,481,317	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	400,317	10,201,108	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-43,176	6,832,324	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-12,900,589	33,736,149	5.00
7.00	00700	OPERATION OF PLANT	0	7,812,682	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	411,886	8.00
9.00	00900	HOUSEKEEPING	0	1,586,166	9.00
10.00	01000	DIETARY	0	823,592	10.00
11.00	01100	CAFETERIA	-238,092	920,256	11.00
13.00	01300	NURSING ADMINISTRATION	-153,704	1,862,259	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,047,893	14.00
15.00	01500	PHARMACY	0	1,741,267	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,163	1,280,083	16.00
17.00	01700	SOCIAL SERVICE	0	734,698	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	7,588,539	30.00
31.00	03100	INTENSIVE CARE UNIT	-487,500	2,358,982	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	0	488,673	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	4,855	6,117,627	50.00
51.00	05100	RECOVERY ROOM	0	1,264,850	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-12,658	1,671,959	52.00
53.00	05300	ANESTHESIOLOGY	0	2,327,517	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,306,213	54.00
54.01	05401	ULTRASOUND	0	427,483	54.01
56.00	05600	RADIOISOTOPE	0	406,048	56.00
57.00	05700	CT SCAN	0	552,302	57.00
58.00	05800	MRI	0	294,960	58.00
60.00	06000	LABORATORY	-134,730	5,311,692	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	-750	841,543	65.00
66.00	06600	PHYSICAL THERAPY	-52,285	2,046,034	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	603,700	67.00
68.00	06800	SPEECH PATHOLOGY	0	427,464	68.00
69.00	06900	ELECTROCARDIOLOGY	4,855	6,064,435	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-17,548	1,623,708	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,727,468	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-11,208	4,519,325	73.00
74.00	07400	RENAL DIALYSIS	0	187,864	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	76.00
76.01	03610	SLEEP LAB	-2,250	257,105	76.01
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-3,142,945	0	90.00
91.00	09100	EMERGENCY	-71,150	2,908,550	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)	-17,044,336	129,795,721	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	600	1,210,294	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	105,690	194.00
194.01	07951	MARKETING	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-17,043,736	131,111,705	200.00

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 4:51 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,124,037	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	35,715	2.00
	0		0	6,159,752	
	B - RENTAL AND LEASE EXPENSES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,277	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	754,830	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	0		0	762,107	
	C - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	182,988	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,094,553	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	52,213	3.00
	0		0	1,329,754	
	D - REPAIRS AND MAINTENANCE				
1.00	OPERATION OF PLANT	7.00	0	3,453,866	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
	0		0	3,453,866	
	E - CHIEF NURSING OFFICER COSTS				
1.00	NURSING ADMINISTRATION	13.00	235,352	0	1.00
	0		235,352	0	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,641,256	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,727,468	2.00
	0		0	5,368,724	
	G - COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,530,533	1.00
	0		0	4,530,533	

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 4:51 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	H - LABOR AND DELIVERY COSTS				
1.00	NURSERY	43.00	417,212	71,461	1.00
2.00	ADULTS & PEDIATRICS	30.00	1,205	206	2.00
	0		418,417	71,667	
	I - DIETARY COSTS TO CAFETERIA				
1.00	CAFETERIA	11.00	297,776	860,572	1.00
	0		297,776	860,572	
500.00	Grand Total: Increases		951,545	22,536,975	500.00

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 4:51 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,120,169	0	1.00
2.00	PHYSICAL THERAPY	66.00	0	39,583	0	2.00
	0		0	6,159,752		
	B - RENTAL AND LEASE EXPENSES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	424	11	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	14,473	10	2.00
3.00	OPERATION OF PLANT	7.00	0	22,159	0	3.00
4.00	DIETARY	10.00	0	3,910	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	5,286	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	40,577	0	6.00
7.00	PHARMACY	15.00	0	58	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,114	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	13,407	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	7,541	0	10.00
11.00	OPERATING ROOM	50.00	0	209,843	0	11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,143	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	97,648	0	13.00
14.00	LABORATORY	60.00	0	23,549	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	32,069	0	15.00
16.00	PHYSICAL THERAPY	66.00	0	319	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	0	284,440	0	17.00
18.00	SLEEP LAB	76.01	0	2,979	0	18.00
19.00	EMERGENCY	91.00	0	168	0	19.00
	0		0	762,107		
	C - OTHER CAPITAL COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,329,754	12	1.00
2.00		0.00	0	0	13	2.00
3.00		0.00	0	0	13	3.00
	0		0	1,329,754		
	D - REPAIRS AND MAINTENANCE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,030	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,143,238	0	2.00
3.00	HOUSEKEEPING	9.00	0	1,894	0	3.00
4.00	DIETARY	10.00	0	15,468	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	959	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	79,183	0	6.00
7.00	PHARMACY	15.00	0	68,186	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	676	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	9,095	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	11,610	0	10.00
11.00	OPERATING ROOM	50.00	0	484,808	0	11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	12,627	0	12.00
13.00	ANESTHESIOLOGY	53.00	0	18,004	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	457,203	0	14.00
15.00	ULTRASOUND	54.01	0	37,760	0	15.00
16.00	RADIOISOTOPE	56.00	0	58,877	0	16.00
17.00	CT SCAN	57.00	0	56,595	0	17.00
18.00	MRI	58.00	0	90,475	0	18.00
19.00	LABORATORY	60.00	0	103,867	0	19.00
20.00	RESPIRATORY THERAPY	65.00	0	5,466	0	20.00
21.00	PHYSICAL THERAPY	66.00	0	14,056	0	21.00
22.00	OCCUPATIONAL THERAPY	67.00	0	6,954	0	22.00
23.00	SPEECH PATHOLOGY	68.00	0	735	0	23.00
24.00	ELECTROCARDIOLOGY	69.00	0	550,784	0	24.00
25.00	SLEEP LAB	76.01	0	6,513	0	25.00
26.00	EMERGENCY	91.00	0	6,632	0	26.00
27.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	211,171	0	27.00
	0		0	3,453,866		
	E - CHIEF NURSING OFFICER COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	235,352	0	0	1.00
	0		235,352	0		
	F - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,368,724	0	1.00
2.00		0.00	0	0	0	2.00
	0		0	5,368,724		
	G - COST OF DRUGS/IV SOLUTIONS					
1.00	PHARMACY	15.00	0	4,530,533	0	1.00
	0		0	4,530,533		
	H - LABOR AND DELIVERY COSTS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	418,417	71,667	0	1.00
2.00		0.00	0	0	0	2.00
	0		418,417	71,667		

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 4:51 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	I - DIETARY COSTS TO CAFETERIA						
1.00	DIETARY	10.00	297,776	860,572	0		1.00
	0		297,776	860,572			
500.00	Grand Total: Decreases		951,545	22,536,975			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2019 4:51 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,438,244	0	0	0	229,443	1.00
2.00	Land Improvements	1,261,034	252,885	0	252,885	0	2.00
3.00	Buildings and Fixtures	32,844,267	0	0	0	878,371	3.00
4.00	Building Improvements	801,613	0	0	0	320,957	4.00
5.00	Fixed Equipment	1,437,555	1,428,284	0	1,428,284	0	5.00
6.00	Movable Equipment	26,810,992	6,666,997	0	6,666,997	10,244,922	6.00
7.00	HIT designated Assets	5,133	0	0	0	5,133	7.00
8.00	Subtotal (sum of lines 1-7)	64,598,838	8,348,166	0	8,348,166	11,678,826	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	64,598,838	8,348,166	0	8,348,166	11,678,826	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,208,801	0	1.00
2.00	Land Improvements	1,513,919	0	2.00
3.00	Buildings and Fixtures	31,965,896	0	3.00
4.00	Building Improvements	480,656	0	4.00
5.00	Fixed Equipment	2,865,839	0	5.00
6.00	Movable Equipment	23,233,067	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	61,268,178	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	61,268,178	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II Date/Time Prepared: 5/30/2019 4:51 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	5,375,114	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,993,748	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	14,368,862	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	5,375,114	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,993,748	2.00
3.00	Total (sum of lines 1-2)	0	14,368,862	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2019 4:51 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	38,035,111	0	38,035,111	0.620797	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,233,067	0	23,233,067	0.379203	0	2.00
3.00	Total (sum of lines 1-2)	61,268,178	0	61,268,178	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	5,375,114	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,993,748	749,083	2.00
3.00	Total (sum of lines 1-2)	0	0	0	14,368,862	749,083	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	-171,338	182,988	1,094,553	0	6,481,317	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	406,064	0	52,213	0	10,201,108	2.00
3.00	Total (sum of lines 1-2)	234,726	182,988	1,146,766	0	16,682,425	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/30/2019 4:51 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	-27,067	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-29,036	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,445,113			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	-11,011,793			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-238,092	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	B	-17,548	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-11,208	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-7,163	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		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TRAINING REVENUE	B	-153,704	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/30/2019 4:51 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	
34.00	TELEPHONE COMMISSION	B	-45,871	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	TELEVISION RENTAL	B	0	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	RENTAL INCOME	B	-248,797	CAP REL COSTS-BLDG & FIXT	1.00	11	36.00
37.00	OTHER MISCELLANEOUS REVENUE	B	-163,457	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	TELEPHONE BENEFIT COST	A	-2,517	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	MARKETING AND ADVERTISTING COST	A	-622,914	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	LOBBYING EXPENSE	A	-332	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	RECRUITING FEES - A&G	A	-56,133	ADMINISTRATIVE & GENERAL	5.00	0	41.00
41.01	RECRUITING FEES - SURGERY	A	4,855	OPERATING ROOM	50.00	0	41.01
41.02	RECRUITING FEES - PHYSICAL THERAPY	A	-52,285	PHYSICAL THERAPY	66.00	0	41.02
41.03	RECRUITING FEES - PERSONNEL	A	-40,659	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.03
41.04	RECRUITING FEES - CARDIOLOGY	A	4,855	ELECTROCARDIOLOGY	69.00	0	41.04
42.00	CHARITABLE CONTRIBUTIONS	A	-135,707	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	MEDICAL STAFF STIPEND	A	-253,750	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	MINORITY INTEREST	A	517,012	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.09	TELEPHONE DEPRECIATION	A	-334	CAP REL COSTS-MVBLE EQUIP	2.00	10	45.09
45.10	TELEVISION DEPRECIATION	A	-5,413	CAP REL COSTS-MVBLE EQUIP	2.00	10	45.10
45.11	ENTERTAINMENT	A	-2,165	ADMINISTRATIVE & GENERAL	5.00	0	45.11
45.12	MOB AUTO INSURANCE	A	600	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-17,043,736				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: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2019 4:51 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	0.00			0	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	6,072	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	1,056	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	PASI Operating Costs	95,598	278,705	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	Shared Service Center Alloca	1,852,021	1,265,000	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	64,110	0	4.04
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm	405,008	0	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	Non-Capital Home Office Cost	4,102,514	0	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	Malpractice Costs	352,698	1,397,141	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	Interest Expense	0	9,559,862	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	Management Fees	0	3,026,978	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	401K Fees	0	5,164	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	Audit Fees	0	103,172	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	Corporate Overhead Allocatio	0	1,996,171	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	HIIM Allocation	0	227,849	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	PASI Lien Unit Collection Fe	0	30,828	4.14
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,879,077	17,890,870	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	CHS	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0006	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/30/2019 4:51 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	0	0	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	6,072	11	4.00
4.01	1,056	11	4.01
4.02	-183,107	0	4.02
4.03	587,021	0	4.03
4.04	64,110	11	4.04
4.05	405,008	11	4.05
4.06	4,102,514	0	4.06
4.07	-1,044,443	0	4.07
4.08	-9,559,862	0	4.08
4.09	-3,026,978	0	4.09
4.10	-5,164	0	4.10
4.11	-103,172	0	4.11
4.12	-1,996,171	0	4.12
4.13	-227,849	0	4.13
4.14	-30,828	0	4.14
5.00	-11,011,793		5.00

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

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

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

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

	Type of Business	
6.00	HEALTHCARE	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2019 4:51 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	31.00	INTENSIVE CARE UNIT	487,500	487,500	0	197,500	0	1.00
2.00	76.01	SLEEP LAB	2,250	2,250	0	211,500	0	2.00
3.00	65.00	RESPIRATORY THERAPY	750	750	0	211,500	0	3.00
4.00	60.00	LABORATORY	134,730	134,730	0	260,300	0	4.00
5.00	91.00	EMERGENCY	71,150	71,150	0	211,500	0	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	593,130	593,130	0	211,500	0	6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	12,658	12,658	0	237,100	0	7.00
8.00	90.00	CLINIC	3,142,945	3,142,945	0	211,500	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			4,445,113	4,445,113	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	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	1.00
2.00	76.01	SLEEP LAB	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	7.00
8.00	90.00	CLINIC	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	31.00	INTENSIVE CARE UNIT	0	0	0	487,500	1.00
2.00	76.01	SLEEP LAB	0	0	0	2,250	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	750	3.00
4.00	60.00	LABORATORY	0	0	0	134,730	4.00
5.00	91.00	EMERGENCY	0	0	0	71,150	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	593,130	6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	12,658	7.00
8.00	90.00	CLINIC	0	0	0	3,142,945	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	4,445,113	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/30/2019 4:51 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	6,481,317	6,481,317				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	10,201,108		10,201,108			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,832,324	39,897	62,795	6,935,016		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	33,736,149	517,119	813,906	1,177,207	36,244,381	5.00
7.00	00700	OPERATION OF PLANT	7,812,682	1,931,339	3,039,782	195,912	12,979,715	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	411,886	5,216	8,209	3,698	429,009	8.00
9.00	00900	HOUSEKEEPING	1,586,166	81,047	127,562	54,373	1,849,148	9.00
10.00	01000	DIETARY	823,592	80,165	126,173	37,055	1,066,985	10.00
11.00	01100	CAFETERIA	920,256	57,102	89,874	52,116	1,119,348	11.00
13.00	01300	NURSING ADMINISTRATION	1,862,259	21,996	34,620	311,671	2,230,546	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,047,893	34,834	54,826	141,974	1,279,527	14.00
15.00	01500	PHARMACY	1,741,267	34,300	53,986	261,244	2,090,797	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,280,083	37,251	58,631	114,737	1,490,702	16.00
17.00	01700	SOCIAL SERVICE	734,698	13,785	21,697	110,778	880,958	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,588,539	296,399	466,509	900,141	9,251,588	30.00
31.00	03100	INTENSIVE CARE UNIT	2,358,982	146,163	230,050	339,819	3,075,014	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	488,673	12,675	19,949	129,661	650,958	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,117,627	391,601	616,351	354,139	7,479,718	50.00
51.00	05100	RECOVERY ROOM	1,264,850	0	0	204,075	1,468,925	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,671,959	175,160	275,689	197,346	2,320,154	52.00
53.00	05300	ANESTHESIOLOGY	2,327,517	0	0	7,668	2,335,185	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,306,213	129,699	204,136	317,298	2,957,346	54.00
54.01	05401	ULTRASOUND	427,483	21,353	33,609	66,780	549,225	54.01
56.00	05600	RADIOISOTOPE	406,048	0	0	36,916	442,964	56.00
57.00	05700	CT SCAN	552,302	21,430	33,729	79,123	686,584	57.00
58.00	05800	MRI	294,960	92,774	146,020	42,411	576,165	58.00
60.00	06000	LABORATORY	5,311,692	67,185	105,744	386,927	5,871,548	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	15,560	24,491	0	40,051	62.00
65.00	06500	RESPIRATORY THERAPY	841,543	13,916	21,903	129,083	1,006,445	65.00
66.00	06600	PHYSICAL THERAPY	2,046,034	343,123	540,050	311,624	3,240,831	66.00
67.00	06700	OCCUPATIONAL THERAPY	603,700	3,746	5,896	33,990	647,332	67.00
68.00	06800	SPEECH PATHOLOGY	427,464	2,210	3,479	113,934	547,087	68.00
69.00	06900	ELECTROCARDIOLOGY	6,064,435	266,835	419,978	374,604	7,125,852	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,623,708	0	0	0	1,623,708	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,727,468	0	0	0	3,727,468	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,519,325	0	0	0	4,519,325	73.00
74.00	07400	RENAL DIALYSIS	187,864	25,393	39,967	0	253,224	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	257,105	0	0	40,154	297,259	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,908,550	110,730	174,281	363,133	3,556,694	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)	129,795,721	4,990,003	7,853,892	6,889,591	125,911,766	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,858	37,550	0	61,408	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,210,294	0	0	29,095	1,239,389	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	105,690	1,467,456	2,309,666	16,330	3,899,142	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	131,111,705	6,481,317	10,201,108	6,935,016	131,111,705	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/30/2019 4:51 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,244,381					5.00
7.00	00700	OPERATION OF PLANT	4,958,974	17,938,689				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	163,904	23,433	616,346			8.00
9.00	00900	HOUSEKEEPING	706,473	364,109	0	2,919,730		9.00
10.00	01000	DIETARY	407,645	360,146	0	59,912	1,894,688	10.00
11.00	01100	CAFETERIA	427,650	256,535	0	42,676	0	11.00
13.00	01300	NURSING ADMINISTRATION	852,187	98,818	0	16,439	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	488,847	156,494	0	26,034	0	14.00
15.00	01500	PHARMACY	798,795	154,097	0	25,635	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	569,527	167,354	0	27,840	0	16.00
17.00	01700	SOCIAL SERVICE	336,573	61,932	0	10,303	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,534,597	1,331,593	239,695	221,518	876,663	30.00
31.00	03100	INTENSIVE CARE UNIT	1,174,818	656,648	48,333	109,237	110,188	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	248,700	56,942	0	9,473	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	2,857,649	1,759,297	50,455	292,669	0	50.00
51.00	05100	RECOVERY ROOM	561,207	0	30,117	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	886,422	786,921	36,320	130,909	113,037	52.00
53.00	05300	ANESTHESIOLOGY	892,164	0	10,535	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,129,863	582,682	54,174	96,932	0	54.00
54.01	05401	ULTRASOUND	209,833	95,931	0	15,959	0	54.01
56.00	05600	RADIOISOTOPE	169,236	0	0	0	0	56.00
57.00	05700	CT SCAN	262,311	96,274	0	16,016	0	57.00
58.00	05800	MRI	220,126	416,795	0	69,336	0	58.00
60.00	06000	LABORATORY	2,243,243	301,834	0	50,212	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	15,302	69,906	0	11,629	0	62.00
65.00	06500	RESPIRATORY THERAPY	384,515	62,519	0	10,400	0	65.00
66.00	06600	PHYSICAL THERAPY	1,238,169	1,541,507	11,736	256,438	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	247,315	16,828	0	2,799	0	67.00
68.00	06800	SPEECH PATHOLOGY	209,016	9,931	0	1,652	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,722,453	1,198,776	20,882	199,423	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	620,343	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,424,090	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,726,622	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	96,745	114,081	0	18,978	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	113,569	0	4,336	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,358,846	497,464	103,177	82,756	21,092	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)	34,257,729	11,238,847	609,760	1,805,175	1,120,980	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,461	107,183	0	17,830	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	473,512	0	0	0	773,708	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	1,489,679	6,592,659	6,586	1,096,725	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,244,381	17,938,689	616,346	2,919,730	1,894,688	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 4:51 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,846,209					11.00
13.00	01300	NURSING ADMINISTRATION	79,701	3,277,691				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	87,692	0	2,038,594			14.00
15.00	01500	PHARMACY	76,070	109	0	3,145,503		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,085	0	0	0	2,310,508	16.00
17.00	01700	SOCIAL SERVICE	36,885	106,152	504	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	344,068	983,276	66,906	0	177,112	30.00
31.00	03100	INTENSIVE CARE UNIT	108,555	474,961	37,539	0	41,792	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	28,975	0	0	0	9,363	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	126,836	256,937	304,226	0	421,584	50.00
51.00	05100	RECOVERY ROOM	60,452	307,666	1,526	0	48,251	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	70,460	437,401	20,133	0	32,540	52.00
53.00	05300	ANESTHESIOLOGY	4,157	0	11,544	0	74,036	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,906	106,809	29,207	0	72,126	54.00
54.01	05401	ULTRASOUND	15,658	0	2,457	0	35,823	54.01
56.00	05600	RADIOISOTOPE	8,111	0	22,674	0	46,180	56.00
57.00	05700	CT SCAN	29,338	0	8,833	0	116,948	57.00
58.00	05800	MRI	12,550	0	4,507	0	38,972	58.00
60.00	06000	LABORATORY	168,685	0	309,871	0	292,530	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	2,269	62.00
65.00	06500	RESPIRATORY THERAPY	48,789	0	5,108	0	31,256	65.00
66.00	06600	PHYSICAL THERAPY	87,127	0	4,703	0	48,611	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,887	0	104	0	20,093	67.00
68.00	06800	SPEECH PATHOLOGY	35,916	0	391	0	10,840	68.00
69.00	06900	ELECTROCARDIOLOGY	108,596	159,618	375,735	0	201,179	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	240,037	0	25,886	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	545,152	0	65,730	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,145,503	303,316	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	7,294	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	13,923	0	1,143	0	13,739	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	119,734	444,762	46,011	0	173,038	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)	1,831,156	3,277,691	2,038,311	3,145,503	2,310,508	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	8,031	0	125	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	7,022	0	158	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	1,846,209	3,277,691	2,038,594	3,145,503	2,310,508	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 4:51 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	1,433,307					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,079,163	18,106,179	0	18,106,179		30.00
31.00	03100	INTENSIVE CARE UNIT	235,878	6,072,963	0	6,072,963		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	118,266	1,122,677	0	1,122,677		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,549,371	0	13,549,371		50.00
51.00	05100	RECOVERY ROOM	0	2,478,144	0	2,478,144		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,834,297	0	4,834,297		52.00
53.00	05300	ANESTHESIOLOGY	0	3,327,621	0	3,327,621		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,123,045	0	5,123,045		54.00
54.01	05401	ULTRASOUND	0	924,886	0	924,886		54.01
56.00	05600	RADIOISOTOPE	0	689,165	0	689,165		56.00
57.00	05700	CT SCAN	0	1,216,304	0	1,216,304		57.00
58.00	05800	MRI	0	1,338,451	0	1,338,451		58.00
60.00	06000	LABORATORY	0	9,237,923	0	9,237,923		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	139,157	0	139,157		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,549,032	0	1,549,032		65.00
66.00	06600	PHYSICAL THERAPY	0	6,429,122	0	6,429,122		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	944,358	0	944,358		67.00
68.00	06800	SPEECH PATHOLOGY	0	814,833	0	814,833		68.00
69.00	06900	ELECTROCARDIOLOGY	0	12,112,514	0	12,112,514		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,509,974	0	2,509,974		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,762,440	0	5,762,440		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,694,766	0	9,694,766		73.00
74.00	07400	RENAL DIALYSIS	0	490,322	0	490,322		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	443,969	0	443,969		76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	6,403,574	0	6,403,574		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		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,433,307	115,315,087	0	115,315,087		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	209,882	0	209,882		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,494,765	0	2,494,765		192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	13,091,971	0	13,091,971		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,433,307	131,111,705	0	131,111,705		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 4:51 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	39,897	62,795	102,692	102,692	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	517,119	813,906	1,331,025	17,418	5.00
7.00	00700	OPERATION OF PLANT	0	1,931,339	3,039,782	4,971,121	2,901	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,216	8,209	13,425	55	8.00
9.00	00900	HOUSEKEEPING	0	81,047	127,562	208,609	805	9.00
10.00	01000	DIETARY	0	80,165	126,173	206,338	549	10.00
11.00	01100	CAFETERIA	0	57,102	89,874	146,976	772	11.00
13.00	01300	NURSING ADMINISTRATION	0	21,996	34,620	56,616	4,616	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	34,834	54,826	89,660	2,103	14.00
15.00	01500	PHARMACY	0	34,300	53,986	88,286	3,869	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37,251	58,631	95,882	1,699	16.00
17.00	01700	SOCIAL SERVICE	0	13,785	21,697	35,482	1,641	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	296,399	466,509	762,908	13,331	30.00
31.00	03100	INTENSIVE CARE UNIT	0	146,163	230,050	376,213	5,033	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	12,675	19,949	32,624	1,920	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	391,601	616,351	1,007,952	5,245	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	3,022	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	175,160	275,689	450,849	2,923	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	114	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	129,699	204,136	333,835	4,699	54.00
54.01	05401	ULTRASOUND	0	21,353	33,609	54,962	989	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	547	56.00
57.00	05700	CT SCAN	0	21,430	33,729	55,159	1,172	57.00
58.00	05800	MRI	0	92,774	146,020	238,794	628	58.00
60.00	06000	LABORATORY	0	67,185	105,744	172,929	5,730	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	15,560	24,491	40,051	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	13,916	21,903	35,819	1,912	65.00
66.00	06600	PHYSICAL THERAPY	0	343,123	540,050	883,173	4,615	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,746	5,896	9,642	503	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,210	3,479	5,689	1,687	68.00
69.00	06900	ELECTROCARDIOLOGY	0	266,835	419,978	686,813	5,548	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	25,393	39,967	65,360	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	595	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	110,730	174,281	285,011	5,378	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	4,990,003	7,853,892	12,843,895	102,019	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,858	37,550	61,408	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	431	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	1,467,456	2,309,666	3,777,122	242	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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	6,481,317	10,201,108	16,682,425	102,692	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 4:51 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,348,443					5.00
7.00	00700	OPERATION OF PLANT	184,493	5,158,515				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,098	6,738	26,316			8.00
9.00	00900	HOUSEKEEPING	26,284	104,705	0	340,403		9.00
10.00	01000	DIETARY	15,166	103,565	0	6,985	332,603	10.00
11.00	01100	CAFETERIA	15,910	73,770	0	4,975	0	11.00
13.00	01300	NURSING ADMINISTRATION	31,705	28,416	0	1,917	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,187	45,002	0	3,035	0	14.00
15.00	01500	PHARMACY	29,719	44,313	0	2,989	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,189	48,125	0	3,246	0	16.00
17.00	01700	SOCIAL SERVICE	12,522	17,809	0	1,201	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	131,502	382,918	10,234	25,826	153,893	30.00
31.00	03100	INTENSIVE CARE UNIT	43,708	188,828	2,064	12,736	19,343	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	9,253	16,375	0	1,104	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	106,317	505,910	2,154	34,121	0	50.00
51.00	05100	RECOVERY ROOM	20,879	0	1,286	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,979	226,290	1,551	15,262	19,843	52.00
53.00	05300	ANESTHESIOLOGY	33,192	0	450	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,036	167,558	2,313	11,301	0	54.00
54.01	05401	ULTRASOUND	7,807	27,586	0	1,861	0	54.01
56.00	05600	RADIOISOTOPE	6,296	0	0	0	0	56.00
57.00	05700	CT SCAN	9,759	27,685	0	1,867	0	57.00
58.00	05800	MRI	8,190	119,855	0	8,084	0	58.00
60.00	06000	LABORATORY	83,458	86,797	0	5,854	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	569	20,102	0	1,356	0	62.00
65.00	06500	RESPIRATORY THERAPY	14,306	17,978	0	1,213	0	65.00
66.00	06600	PHYSICAL THERAPY	46,065	443,281	501	29,897	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,201	4,839	0	326	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,776	2,856	0	193	0	68.00
69.00	06900	ELECTROCARDIOLOGY	101,287	344,724	892	23,250	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,079	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,982	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,238	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,599	32,805	0	2,213	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	4,225	0	185	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	50,555	143,053	4,405	9,648	3,703	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)	1,274,531	3,231,883	26,035	210,460	196,782	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	873	30,822	0	2,079	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,617	0	0	0	135,821	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	55,422	1,895,810	281	127,864	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	1,348,443	5,158,515	26,316	340,403	332,603	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/30/2019 4:51 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	242,403					11.00
13.00	01300	NURSING ADMINISTRATION	10,465	133,735				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,514	0	169,501			14.00
15.00	01500	PHARMACY	9,988	4	0	179,168		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,233	0	0	0	177,374	16.00
17.00	01700	SOCIAL SERVICE	4,843	4,331	42	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,174	40,119	5,563	0	13,581	30.00
31.00	03100	INTENSIVE CARE UNIT	14,253	19,379	3,121	0	3,205	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	3,804	0	0	0	718	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,653	10,484	25,295	0	32,527	50.00
51.00	05100	RECOVERY ROOM	7,937	12,553	127	0	3,700	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,251	17,847	1,674	0	2,495	52.00
53.00	05300	ANESTHESIOLOGY	546	0	960	0	5,677	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,330	4,358	2,428	0	5,531	54.00
54.01	05401	ULTRASOUND	2,056	0	204	0	2,747	54.01
56.00	05600	RADIOISOTOPE	1,065	0	1,885	0	3,541	56.00
57.00	05700	CT SCAN	3,852	0	734	0	8,968	57.00
58.00	05800	MRI	1,648	0	375	0	2,988	58.00
60.00	06000	LABORATORY	22,148	0	25,764	0	22,432	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	174	62.00
65.00	06500	RESPIRATORY THERAPY	6,406	0	425	0	2,397	65.00
66.00	06600	PHYSICAL THERAPY	11,440	0	391	0	3,728	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,298	0	9	0	1,541	67.00
68.00	06800	SPEECH PATHOLOGY	4,716	0	33	0	831	68.00
69.00	06900	ELECTROCARDIOLOGY	14,258	6,513	31,240	0	15,427	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	19,958	0	1,985	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	45,329	0	5,040	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	179,168	23,259	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	559	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,828	0	95	0	1,054	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	15,721	18,147	3,826	0	13,269	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)	240,427	133,735	169,478	179,168	177,374	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	1,054	0	10	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	922	0	13	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	242,403	133,735	169,501	179,168	177,374	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 4:51 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	77,871					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	58,631	1,643,680	0	1,643,680		30.00
31.00	03100	INTENSIVE CARE UNIT	12,815	700,698	0	700,698		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	6,425	72,223	0	72,223		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,746,658	0	1,746,658		50.00
51.00	05100	RECOVERY ROOM	0	49,504	0	49,504		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	780,964	0	780,964		52.00
53.00	05300	ANESTHESIOLOGY	0	40,939	0	40,939		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	586,389	0	586,389		54.00
54.01	05401	ULTRASOUND	0	98,212	0	98,212		54.01
56.00	05600	RADIOISOTOPE	0	13,334	0	13,334		56.00
57.00	05700	CT SCAN	0	109,196	0	109,196		57.00
58.00	05800	MRI	0	380,562	0	380,562		58.00
60.00	06000	LABORATORY	0	425,112	0	425,112		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	62,252	0	62,252		62.00
65.00	06500	RESPIRATORY THERAPY	0	80,456	0	80,456		65.00
66.00	06600	PHYSICAL THERAPY	0	1,423,091	0	1,423,091		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	27,359	0	27,359		67.00
68.00	06800	SPEECH PATHOLOGY	0	23,781	0	23,781		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,229,952	0	1,229,952		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	45,022	0	45,022		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	103,351	0	103,351		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	266,665	0	266,665		73.00
74.00	07400	RENAL DIALYSIS	0	104,536	0	104,536		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	7,982	0	7,982		76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	552,716	0	552,716		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		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,871	10,574,634	0	10,574,634		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	95,182	0	95,182		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	154,933	0	154,933		192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	5,857,676	0	5,857,676		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	77,871	16,682,425	0	16,682,425		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 4:51 pm

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	595,217					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		595,217				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,664	3,664	39,625,064			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	47,490	47,490	6,726,318	-36,244,381	94,867,324	5.00
7.00	00700	OPERATION OF PLANT	177,366	177,366	1,119,395	0	12,979,715	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	479	479	21,132	0	429,009	8.00
9.00	00900	HOUSEKEEPING	7,443	7,443	310,674	0	1,849,148	9.00
10.00	01000	DIETARY	7,362	7,362	211,721	0	1,066,985	10.00
11.00	01100	CAFETERIA	5,244	5,244	297,776	0	1,119,348	11.00
13.00	01300	NURSING ADMINISTRATION	2,020	2,020	1,780,815	0	2,230,546	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,199	3,199	811,203	0	1,279,527	14.00
15.00	01500	PHARMACY	3,150	3,150	1,492,689	0	2,090,797	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,421	3,421	655,578	0	1,490,702	16.00
17.00	01700	SOCIAL SERVICE	1,266	1,266	632,961	0	880,958	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,220	27,220	5,143,190	0	9,251,588	30.00
31.00	03100	INTENSIVE CARE UNIT	13,423	13,423	1,941,648	0	3,075,014	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	1,164	1,164	740,854	0	650,958	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,963	35,963	2,023,467	0	7,479,718	50.00
51.00	05100	RECOVERY ROOM	0	0	1,166,039	0	1,468,925	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,086	16,086	1,127,587	0	2,320,154	52.00
53.00	05300	ANESTHESIOLOGY	0	0	43,814	0	2,335,185	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,911	11,911	1,812,967	0	2,957,346	54.00
54.01	05401	ULTRASOUND	1,961	1,961	381,563	0	549,225	54.01
56.00	05600	RADIOISOTOPE	0	0	210,927	0	442,964	56.00
57.00	05700	CT SCAN	1,968	1,968	452,088	0	686,584	57.00
58.00	05800	MRI	8,520	8,520	242,328	0	576,165	58.00
60.00	06000	LABORATORY	6,170	6,170	2,210,807	0	5,871,548	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,429	1,429	0	0	40,051	62.00
65.00	06500	RESPIRATORY THERAPY	1,278	1,278	737,547	0	1,006,445	65.00
66.00	06600	PHYSICAL THERAPY	31,511	31,511	1,780,544	0	3,240,831	66.00
67.00	06700	OCCUPATIONAL THERAPY	344	344	194,209	0	647,332	67.00
68.00	06800	SPEECH PATHOLOGY	203	203	650,994	0	547,087	68.00
69.00	06900	ELECTROCARDIOLOGY	24,505	24,505	2,140,399	0	7,125,852	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,623,708	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,727,468	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,519,325	73.00
74.00	07400	RENAL DIALYSIS	2,332	2,332	0	0	253,224	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	229,431	0	297,259	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	10,169	10,169	2,074,855	0	3,556,694	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)	458,261	458,261	39,365,520	-36,244,381	89,667,385	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,191	2,191	0	0	61,408	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	166,241	0	1,239,389	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	134,765	134,765	93,303	0	3,899,142	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,481,317	10,201,108	6,935,016		36,244,381	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.888998	17.138469	0.175016		0.382053	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			102,692		1,348,443	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002592		0.014214	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 4:51 pm

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 4:51 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	366,697					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	479	513,390				8.00
9.00	00900	HOUSEKEEPING	7,443	0	358,775			9.00
10.00	01000	DIETARY	7,362	0	7,362	103,755		10.00
11.00	01100	CAFETERIA	5,244	0	5,244	0	45,749	11.00
13.00	01300	NURSING ADMINISTRATION	2,020	0	2,020	0	1,975	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,199	0	3,199	0	2,173	14.00
15.00	01500	PHARMACY	3,150	0	3,150	0	1,885	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,421	0	3,421	0	1,365	16.00
17.00	01700	SOCIAL SERVICE	1,266	0	1,266	0	914	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,220	199,655	27,220	48,007	8,526	30.00
31.00	03100	INTENSIVE CARE UNIT	13,423	40,259	13,423	6,034	2,690	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	1,164	0	1,164	0	718	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,963	42,027	35,963	0	3,143	50.00
51.00	05100	RECOVERY ROOM	0	25,086	0	0	1,498	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,086	30,253	16,086	6,190	1,746	52.00
53.00	05300	ANESTHESIOLOGY	0	8,775	0	0	103	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,911	45,125	11,911	0	2,327	54.00
54.01	05401	ULTRASOUND	1,961	0	1,961	0	388	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	201	56.00
57.00	05700	CT SCAN	1,968	0	1,968	0	727	57.00
58.00	05800	MRI	8,520	0	8,520	0	311	58.00
60.00	06000	LABORATORY	6,170	0	6,170	0	4,180	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,429	0	1,429	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,278	0	1,278	0	1,209	65.00
66.00	06600	PHYSICAL THERAPY	31,511	9,776	31,511	0	2,159	66.00
67.00	06700	OCCUPATIONAL THERAPY	344	0	344	0	245	67.00
68.00	06800	SPEECH PATHOLOGY	203	0	203	0	890	68.00
69.00	06900	ELECTROCARDIOLOGY	24,505	17,394	24,505	0	2,691	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	2,332	0	2,332	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	3,612	0	0	345	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	10,169	85,942	10,169	1,155	2,967	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)	229,741	507,904	221,819	61,386	45,376	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,191	0	2,191	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	42,369	199	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	134,765	5,486	134,765	0	174	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	17,938,689	616,346	2,919,730	1,894,688	1,846,209	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.919650	1.200541	8.138053	18.261173	40.355177	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,158,515	26,316	340,403	332,603	242,403	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	14.067514	0.051259	0.948792	3.205658	5.298542	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: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 4:51 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (BILLABLE SUPPLIE)	PHARMACY (100% ALLOCAT)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	12,100,713					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,938,895				14.00
15.00	01500	PHARMACY	402	0	4,554,743			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	516,589,062		16.00
17.00	01700	SOCIAL SERVICE	391,896	3,446	0	0	17,561	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,630,112	457,470	0	39,595,690	13,222	30.00
31.00	03100	INTENSIVE CARE UNIT	1,753,478	256,671	0	9,343,092	2,890	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	2,093,131	1,449	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	948,568	2,080,146	0	94,295,145	0	50.00
51.00	05100	RECOVERY ROOM	1,135,853	10,435	0	10,787,262	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,614,811	137,660	0	7,274,690	0	52.00
53.00	05300	ANESTHESIOLOGY	0	78,930	0	16,551,861	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	394,322	199,700	0	16,124,806	0	54.00
54.01	05401	ULTRASOUND	0	16,798	0	8,008,720	0	54.01
56.00	05600	RADIOISOTOPE	0	155,032	0	10,324,144	0	56.00
57.00	05700	CT SCAN	0	60,395	0	26,145,265	0	57.00
58.00	05800	MRI	0	30,819	0	8,712,648	0	58.00
60.00	06000	LABORATORY	0	2,118,749	0	65,399,051	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	507,271	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	34,926	0	6,987,620	0	65.00
66.00	06600	PHYSICAL THERAPY	0	32,159	0	10,867,562	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	710	0	4,492,138	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,673	0	2,423,380	0	68.00
69.00	06900	ELECTROCARDIOLOGY	589,283	2,569,095	0	44,976,204	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,641,256	0	5,787,201	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,727,468	0	14,694,745	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,554,743	67,810,404	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,630,610	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	7,817	0	3,071,503	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,641,988	314,604	0	38,684,919	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)	12,100,713	13,936,959	4,554,743	516,589,062	17,561	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	853	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	1,083	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	3,277,691	2,038,594	3,145,503	2,310,508	1,433,307	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.270868	0.146252	0.690599	0.004473	81.618757	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	133,735	169,501	179,168	177,374	77,871	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.011052	0.012160	0.039337	0.000343	4.434315	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0006

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

Worksheet C Part I
Date/Time Prepared: 5/30/2019 4:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
					Costs			
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,106,179		18,106,179	0	18,106,179	30.00
31.00	03100	INTENSIVE CARE UNIT	6,072,963		6,072,963	0	6,072,963	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	1,122,677		1,122,677	0	1,122,677	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,549,371		13,549,371	0	13,549,371	50.00
51.00	05100	RECOVERY ROOM	2,478,144		2,478,144	0	2,478,144	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,834,297		4,834,297	0	4,834,297	52.00
53.00	05300	ANESTHESIOLOGY	3,327,621		3,327,621	0	3,327,621	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,123,045		5,123,045	0	5,123,045	54.00
54.01	05401	ULTRASOUND	924,886		924,886	0	924,886	54.01
56.00	05600	RADIOISOTOPE	689,165		689,165	0	689,165	56.00
57.00	05700	CT SCAN	1,216,304		1,216,304	0	1,216,304	57.00
58.00	05800	MRI	1,338,451		1,338,451	0	1,338,451	58.00
60.00	06000	LABORATORY	9,237,923		9,237,923	0	9,237,923	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	139,157		139,157	0	139,157	62.00
65.00	06500	RESPIRATORY THERAPY	1,549,032	0	1,549,032	0	1,549,032	65.00
66.00	06600	PHYSICAL THERAPY	6,429,122	0	6,429,122	0	6,429,122	66.00
67.00	06700	OCCUPATIONAL THERAPY	944,358	0	944,358	0	944,358	67.00
68.00	06800	SPEECH PATHOLOGY	814,833	0	814,833	0	814,833	68.00
69.00	06900	ELECTROCARDIOLOGY	12,112,514		12,112,514	0	12,112,514	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,509,974		2,509,974	0	2,509,974	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,762,440		5,762,440	0	5,762,440	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,694,766		9,694,766	0	9,694,766	73.00
74.00	07400	RENAL DIALYSIS	490,322		490,322	0	490,322	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0		0	0	0	76.00
76.01	03610	SLEEP LAB	443,969		443,969	0	443,969	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	6,403,574		6,403,574	0	6,403,574	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,671,781		1,671,781		1,671,781	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	116,986,868	0	116,986,868	0	116,986,868	200.00
201.00		Less Observation Beds	1,671,781		1,671,781		1,671,781	201.00
202.00		Total (see instructions)	115,315,087	0	115,315,087	0	115,315,087	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 4:51 pm

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		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,730,938		36,730,938			30.00
31.00	03100	INTENSIVE CARE UNIT	9,343,092		9,343,092			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	2,093,131		2,093,131			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,220,603	67,074,542	94,295,145	0.143691	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,322,439	9,464,823	10,787,262	0.229729	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,026,389	248,301	7,274,690	0.664536	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,862,440	11,689,421	16,551,861	0.201042	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,880,643	12,244,163	16,124,806	0.317712	0.000000	54.00
54.01	05401	ULTRASOUND	1,288,186	6,720,534	8,008,720	0.115485	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,244,998	8,079,146	10,324,144	0.066753	0.000000	56.00
57.00	05700	CT SCAN	6,385,349	19,759,916	26,145,265	0.046521	0.000000	57.00
58.00	05800	MRI	1,496,865	7,215,783	8,712,648	0.153622	0.000000	58.00
60.00	06000	LABORATORY	20,829,366	44,569,685	65,399,051	0.141255	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	351,749	155,522	507,271	0.274325	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	6,129,234	858,386	6,987,620	0.221682	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,301,002	8,566,560	10,867,562	0.591588	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,047,867	2,444,271	4,492,138	0.210225	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	568,742	1,854,638	2,423,380	0.336238	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	13,405,854	31,570,350	44,976,204	0.269309	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,750,884	3,036,317	5,787,201	0.433711	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,277,093	8,417,652	14,694,745	0.392143	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,853,151	36,957,253	67,810,404	0.142969	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,630,610	0	1,630,610	0.300699	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	250,206	2,821,297	3,071,503	0.144545	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	8,006,334	30,678,585	38,684,919	0.165532	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,233,907	1,630,845	2,864,752	0.583569	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)	200,531,072	316,057,990	516,589,062			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	200,531,072	316,057,990	516,589,062			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/30/2019 4:51 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.143691	50.00
51.00	05100	RECOVERY ROOM	0.229729	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.664536	52.00
53.00	05300	ANESTHESIOLOGY	0.201042	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.317712	54.00
54.01	05401	ULTRASOUND	0.115485	54.01
56.00	05600	RADIOISOTOPE	0.066753	56.00
57.00	05700	CT SCAN	0.046521	57.00
58.00	05800	MRI	0.153622	58.00
60.00	06000	LABORATORY	0.141255	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.274325	62.00
65.00	06500	RESPIRATORY THERAPY	0.221682	65.00
66.00	06600	PHYSICAL THERAPY	0.591588	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.210225	67.00
68.00	06800	SPEECH PATHOLOGY	0.336238	68.00
69.00	06900	ELECTROCARDIOLOGY	0.269309	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.433711	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.392143	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142969	73.00
74.00	07400	RENAL DIALYSIS	0.300699	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	76.00
76.01	03610	SLEEP LAB	0.144545	76.01
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.165532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.583569	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: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/30/2019 4:51 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	18,106,179		18,106,179	0	18,106,179	30.00
31.00	03100	INTENSIVE CARE UNIT	6,072,963		6,072,963	0	6,072,963	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	1,122,677		1,122,677	0	1,122,677	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,549,371		13,549,371	0	13,549,371	50.00
51.00	05100	RECOVERY ROOM	2,478,144		2,478,144	0	2,478,144	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,834,297		4,834,297	0	4,834,297	52.00
53.00	05300	ANESTHESIOLOGY	3,327,621		3,327,621	0	3,327,621	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,123,045		5,123,045	0	5,123,045	54.00
54.01	05401	ULTRASOUND	924,886		924,886	0	924,886	54.01
56.00	05600	RADIOISOTOPE	689,165		689,165	0	689,165	56.00
57.00	05700	CT SCAN	1,216,304		1,216,304	0	1,216,304	57.00
58.00	05800	MRI	1,338,451		1,338,451	0	1,338,451	58.00
60.00	06000	LABORATORY	9,237,923		9,237,923	0	9,237,923	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	139,157		139,157	0	139,157	62.00
65.00	06500	RESPIRATORY THERAPY	1,549,032	0	1,549,032	0	1,549,032	65.00
66.00	06600	PHYSICAL THERAPY	6,429,122	0	6,429,122	0	6,429,122	66.00
67.00	06700	OCCUPATIONAL THERAPY	944,358	0	944,358	0	944,358	67.00
68.00	06800	SPEECH PATHOLOGY	814,833	0	814,833	0	814,833	68.00
69.00	06900	ELECTROCARDIOLOGY	12,112,514		12,112,514	0	12,112,514	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,509,974		2,509,974	0	2,509,974	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,762,440		5,762,440	0	5,762,440	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,694,766		9,694,766	0	9,694,766	73.00
74.00	07400	RENAL DIALYSIS	490,322		490,322	0	490,322	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0		0	0	0	76.00
76.01	03610	SLEEP LAB	443,969		443,969	0	443,969	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	6,403,574		6,403,574	0	6,403,574	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,671,781		1,671,781		1,671,781	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	116,986,868	0	116,986,868	0	116,986,868	200.00
201.00		Less Observation Beds	1,671,781		1,671,781		1,671,781	201.00
202.00		Total (see instructions)	115,315,087	0	115,315,087	0	115,315,087	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/30/2019 4:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,730,938		36,730,938			30.00
31.00	03100	INTENSIVE CARE UNIT	9,343,092		9,343,092			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	2,093,131		2,093,131			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,220,603	67,074,542	94,295,145	0.143691	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,322,439	9,464,823	10,787,262	0.229729	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,026,389	248,301	7,274,690	0.664536	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,862,440	11,689,421	16,551,861	0.201042	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,880,643	12,244,163	16,124,806	0.317712	0.000000	54.00
54.01	05401	ULTRASOUND	1,288,186	6,720,534	8,008,720	0.115485	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,244,998	8,079,146	10,324,144	0.066753	0.000000	56.00
57.00	05700	CT SCAN	6,385,349	19,759,916	26,145,265	0.046521	0.000000	57.00
58.00	05800	MRI	1,496,865	7,215,783	8,712,648	0.153622	0.000000	58.00
60.00	06000	LABORATORY	20,829,366	44,569,685	65,399,051	0.141255	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	351,749	155,522	507,271	0.274325	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	6,129,234	858,386	6,987,620	0.221682	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,301,002	8,566,560	10,867,562	0.591588	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,047,867	2,444,271	4,492,138	0.210225	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	568,742	1,854,638	2,423,380	0.336238	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	13,405,854	31,570,350	44,976,204	0.269309	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,750,884	3,036,317	5,787,201	0.433711	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,277,093	8,417,652	14,694,745	0.392143	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,853,151	36,957,253	67,810,404	0.142969	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,630,610	0	1,630,610	0.300699	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	250,206	2,821,297	3,071,503	0.144545	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	8,006,334	30,678,585	38,684,919	0.165532	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,233,907	1,630,845	2,864,752	0.583569	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)	200,531,072	316,057,990	516,589,062			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	200,531,072	316,057,990	516,589,062			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/30/2019 4:51 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
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.143691	50.00
51.00	05100	RECOVERY ROOM	0.229729	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.664536	52.00
53.00	05300	ANESTHESIOLOGY	0.201042	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.317712	54.00
54.01	05401	ULTRASOUND	0.115485	54.01
56.00	05600	RADIOISOTOPE	0.066753	56.00
57.00	05700	CT SCAN	0.046521	57.00
58.00	05800	MRI	0.153622	58.00
60.00	06000	LABORATORY	0.141255	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.274325	62.00
65.00	06500	RESPIRATORY THERAPY	0.221682	65.00
66.00	06600	PHYSICAL THERAPY	0.591588	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.210225	67.00
68.00	06800	SPEECH PATHOLOGY	0.336238	68.00
69.00	06900	ELECTROCARDIOLOGY	0.269309	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.433711	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.392143	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142969	73.00
74.00	07400	RENAL DIALYSIS	0.300699	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	76.00
76.01	03610	SLEEP LAB	0.144545	76.01
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.165532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.583569	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: 15-0006

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

Worksheet C Part II

Date/Time Prepared: 5/30/2019 4:51 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	13,549,371	1,746,658	11,802,713	0	0	50.00
51.00	05100	RECOVERY ROOM	2,478,144	49,504	2,428,640	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,834,297	780,964	4,053,333	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,327,621	40,939	3,286,682	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,123,045	586,389	4,536,656	0	0	54.00
54.01	05401	ULTRASOUND	924,886	98,212	826,674	0	0	54.01
56.00	05600	RADIOISOTOPE	689,165	13,334	675,831	0	0	56.00
57.00	05700	CT SCAN	1,216,304	109,196	1,107,108	0	0	57.00
58.00	05800	MRI	1,338,451	380,562	957,889	0	0	58.00
60.00	06000	LABORATORY	9,237,923	425,112	8,812,811	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	139,157	62,252	76,905	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,549,032	80,456	1,468,576	0	0	65.00
66.00	06600	PHYSICAL THERAPY	6,429,122	1,423,091	5,006,031	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	944,358	27,359	916,999	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	814,833	23,781	791,052	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,112,514	1,229,952	10,882,562	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,509,974	45,022	2,464,952	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,762,440	103,351	5,659,089	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,694,766	266,665	9,428,101	0	0	73.00
74.00	07400	RENAL DIALYSIS	490,322	104,536	385,786	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	443,969	7,982	435,987	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,403,574	552,716	5,850,858	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,671,781	151,764	1,520,017	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)	91,685,049	8,309,797	83,375,252	0	0	200.00
201.00		Less Observation Beds	1,671,781	151,764	1,520,017	0	0	201.00
202.00		Total (line 200 minus line 201)	90,013,268	8,158,033	81,855,235	0	0	202.00

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

Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part II | Date/Time Prepared: 5/30/2019 4:51 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	13,549,371	94,295,145	0.143691	50.00
51.00	05100	RECOVERY ROOM	2,478,144	10,787,262	0.229729	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,834,297	7,274,690	0.664536	52.00
53.00	05300	ANESTHESIOLOGY	3,327,621	16,551,861	0.201042	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,123,045	16,124,806	0.317712	54.00
54.01	05401	ULTRASOUND	924,886	8,008,720	0.115485	54.01
56.00	05600	RADIOISOTOPE	689,165	10,324,144	0.066753	56.00
57.00	05700	CT SCAN	1,216,304	26,145,265	0.046521	57.00
58.00	05800	MRI	1,338,451	8,712,648	0.153622	58.00
60.00	06000	LABORATORY	9,237,923	65,399,051	0.141255	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	139,157	507,271	0.274325	62.00
65.00	06500	RESPIRATORY THERAPY	1,549,032	6,987,620	0.221682	65.00
66.00	06600	PHYSICAL THERAPY	6,429,122	10,867,562	0.591588	66.00
67.00	06700	OCCUPATIONAL THERAPY	944,358	4,492,138	0.210225	67.00
68.00	06800	SPEECH PATHOLOGY	814,833	2,423,380	0.336238	68.00
69.00	06900	ELECTROCARDIOLOGY	12,112,514	44,976,204	0.269309	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,509,974	5,787,201	0.433711	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,762,440	14,694,745	0.392143	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,694,766	67,810,404	0.142969	73.00
74.00	07400	RENAL DIALYSIS	490,322	1,630,610	0.300699	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	443,969	3,071,503	0.144545	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	0.000000	90.00
91.00	09100	EMERGENCY	6,403,574	38,684,919	0.165532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,671,781	2,864,752	0.583569	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)	91,685,049	468,421,901		200.00
201.00		Less Observation Beds	1,671,781	0		201.00
202.00		Total (line 200 minus line 201)	90,013,268	468,421,901		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I | Date/Time Prepared: 5/30/2019 4:51 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,643,680	0	1,643,680	14,567	112.84	30.00
31.00	INTENSIVE CARE UNIT	700,698		700,698	2,890	242.46	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	72,223		72,223	1,449	49.84	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	2,416,601		2,416,601	18,906		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	7,380	832,759	30.00
31.00	INTENSIVE CARE UNIT	1,089	264,039	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	8,469	1,096,798	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0006

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

Worksheet D Part II Date/Time Prepared: 5/30/2019 4:51 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	1,746,658	94,295,145	0.018523	8,510,570	157,641	50.00
51.00	05100	RECOVERY ROOM	49,504	10,787,262	0.004589	595,307	2,732	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	780,964	7,274,690	0.107354	0	0	52.00
53.00	05300	ANESTHESIOLOGY	40,939	16,551,861	0.002473	1,780,167	4,402	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	586,389	16,124,806	0.036366	1,098,212	39,938	54.00
54.01	05401	ULTRASOUND	98,212	8,008,720	0.012263	540,041	6,623	54.01
56.00	05600	RADIOISOTOPE	13,334	10,324,144	0.001292	580,185	750	56.00
57.00	05700	CT SCAN	109,196	26,145,265	0.004177	3,218,696	13,444	57.00
58.00	05800	MRI	380,562	8,712,648	0.043679	749,485	32,737	58.00
60.00	06000	LABORATORY	425,112	65,399,051	0.006500	9,880,272	64,222	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62,252	507,271	0.122719	178,654	21,924	62.00
65.00	06500	RESPIRATORY THERAPY	80,456	6,987,620	0.011514	3,268,257	37,631	65.00
66.00	06600	PHYSICAL THERAPY	1,423,091	10,867,562	0.130949	1,329,535	174,101	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,359	4,492,138	0.006090	1,232,702	7,507	67.00
68.00	06800	SPEECH PATHOLOGY	23,781	2,423,380	0.009813	368,983	3,621	68.00
69.00	06900	ELECTROCARDIOLOGY	1,229,952	44,976,204	0.027347	5,855,349	160,126	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	45,022	5,787,201	0.007780	2,454,504	19,096	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	103,351	14,694,745	0.007033	5,776,379	40,625	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	266,665	67,810,404	0.003933	14,073,696	55,352	73.00
74.00	07400	RENAL DIALYSIS	104,536	1,630,610	0.064109	1,091,416	69,970	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	7,982	3,071,503	0.002599	125,396	326	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	552,716	38,684,919	0.014288	3,928,740	56,134	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	151,764	2,864,752	0.052976	403,770	21,390	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	8,309,797	468,421,901		67,040,316	990,292	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III | Date/Time Prepared: 5/30/2019 4:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	14,567	0.00	7,380	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,890	0.00	1,089	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
43.00	04300	NURSERY		0	1,449	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	18,906		8,469	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
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: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 4:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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	ULTRASOUND	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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		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: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 4:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	94,295,145	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	10,787,262	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	7,274,690	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,551,861	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,124,806	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	8,008,720	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	10,324,144	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	26,145,265	0.000000	57.00
58.00	05800	MRI	0	0	0	8,712,648	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	65,399,051	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	507,271	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,987,620	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,867,562	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,492,138	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,423,380	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	44,976,204	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,787,201	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,694,745	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	67,810,404	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,630,610	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	3,071,503	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	38,684,919	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,864,752	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	468,421,901		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 4:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	8,510,570	0	19,440,861	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	595,307	0	2,219,141	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,780,167	0	3,221,956	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,098,212	0	2,188,415	0	54.00
54.01	05401	ULTRASOUND	0.000000	540,041	0	885,021	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	580,185	0	3,367,146	0	56.00
57.00	05700	CT SCAN	0.000000	3,218,696	0	5,804,259	0	57.00
58.00	05800	MRI	0.000000	749,485	0	2,733,174	0	58.00
60.00	06000	LABORATORY	0.000000	9,880,272	0	4,596,177	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	178,654	0	71,709	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,268,257	0	320,451	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,329,535	0	62,840	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,232,702	0	50,916	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	368,983	0	8,662	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	5,855,349	0	10,011,314	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,454,504	0	2,567,435	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,776,379	0	7,702,320	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	14,073,696	0	11,694,709	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,091,416	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	125,396	0	672,880	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	3,928,740	0	5,871,438	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	403,770	0	596,528	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		67,040,316	0	84,087,352	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 4:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.143691	19,440,861	0	0	2,793,477	50.00
51.00	05100	RECOVERY ROOM	0.229729	2,219,141	0	0	509,801	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.664536	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.201042	3,221,956	0	0	647,748	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.317712	2,188,415	0	0	695,286	54.00
54.01	05401	ULTRASOUND	0.115485	885,021	0	0	102,207	54.01
56.00	05600	RADIOISOTOPE	0.066753	3,367,146	0	0	224,767	56.00
57.00	05700	CT SCAN	0.046521	5,804,259	0	0	270,020	57.00
58.00	05800	MRI	0.153622	2,733,174	0	0	419,876	58.00
60.00	06000	LABORATORY	0.141255	4,596,177	0	0	649,233	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.274325	71,709	0	0	19,672	62.00
65.00	06500	RESPIRATORY THERAPY	0.221682	320,451	0	0	71,038	65.00
66.00	06600	PHYSICAL THERAPY	0.591588	62,840	0	0	37,175	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.210225	50,916	0	0	10,704	67.00
68.00	06800	SPEECH PATHOLOGY	0.336238	8,662	0	0	2,912	68.00
69.00	06900	ELECTROCARDIOLOGY	0.269309	10,011,314	0	0	2,696,137	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.433711	2,567,435	8,857	0	1,113,525	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.392143	7,702,320	747	0	3,020,411	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142969	11,694,709	0	68,449	1,671,981	73.00
74.00	07400	RENAL DIALYSIS	0.300699	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.144545	672,880	0	0	97,261	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.165532	5,871,438	0	0	971,911	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.583569	596,528	0	0	348,115	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		84,087,352	9,604	68,449	16,373,257	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		84,087,352	9,604	68,449	16,373,257	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/30/2019 4:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,841	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	293	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,786	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
		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)	4,134	9,786	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	4,134	9,786	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I | Date/Time Prepared: 5/30/2019 4:51 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	1,643,680	0	1,643,680	14,567	112.84	30.00
31.00	INTENSIVE CARE UNIT	700,698		700,698	2,890	242.46	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	72,223		72,223	1,449	49.84	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	2,416,601		2,416,601	18,906		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	1,086	122,544	30.00
31.00	INTENSIVE CARE UNIT	98	23,761	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
43.00	NURSERY	485	24,172	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	1,669	170,477	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/30/2019 4:51 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	1,746,658	94,295,145	0.018523	1,760,990	32,619	50.00
51.00	05100	RECOVERY ROOM	49,504	10,787,262	0.004589	149,855	688	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	780,964	7,274,690	0.107354	905,602	97,220	52.00
53.00	05300	ANESTHESIOLOGY	40,939	16,551,861	0.002473	408,723	1,011	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	586,389	16,124,806	0.036366	92,374	3,359	54.00
54.01	05401	ULTRASOUND	98,212	8,008,720	0.012263	72,073	884	54.01
56.00	05600	RADIOISOTOPE	13,334	10,324,144	0.001292	64,602	83	56.00
57.00	05700	CT SCAN	109,196	26,145,265	0.004177	359,142	1,500	57.00
58.00	05800	MRI	380,562	8,712,648	0.043679	154,119	6,732	58.00
60.00	06000	LABORATORY	425,112	65,399,051	0.006500	1,468,699	9,547	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62,252	507,271	0.122719	7,261	891	62.00
65.00	06500	RESPIRATORY THERAPY	80,456	6,987,620	0.011514	320,381	3,689	65.00
66.00	06600	PHYSICAL THERAPY	1,423,091	10,867,562	0.130949	111,774	14,637	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,359	4,492,138	0.006090	73,233	446	67.00
68.00	06800	SPEECH PATHOLOGY	23,781	2,423,380	0.009813	32,354	317	68.00
69.00	06900	ELECTROCARDIOLOGY	1,229,952	44,976,204	0.027347	618,614	16,917	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	45,022	5,787,201	0.007780	296,380	2,306	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	103,351	14,694,745	0.007033	500,714	3,522	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	266,665	67,810,404	0.003933	1,682,114	6,616	73.00
74.00	07400	RENAL DIALYSIS	104,536	1,630,610	0.064109	90,168	5,781	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	7,982	3,071,503	0.002599	31,781	83	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	552,716	38,684,919	0.014288	489,836	6,999	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	151,764	2,864,752	0.052976	47,051	2,493	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	8,309,797	468,421,901		9,737,840	218,340	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/30/2019 4:51 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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	14,567	0.00	1,086	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,890	0.00	98	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
43.00	04300	NURSERY		0	1,449	0.00	485	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	18,906		1,669	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
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: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 4:51 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	ULTRASOUND	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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		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: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 4:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	94,295,145	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	10,787,262	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	7,274,690	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,551,861	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,124,806	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	8,008,720	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	10,324,144	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	26,145,265	0.000000	57.00
58.00	05800	MRI	0	0	0	8,712,648	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	65,399,051	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	507,271	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,987,620	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,867,562	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,492,138	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,423,380	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	44,976,204	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,787,201	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,694,745	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	67,810,404	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,630,610	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	3,071,503	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	38,684,919	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,864,752	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	468,421,901		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/30/2019 4:51 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	1,760,990	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	149,855	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	905,602	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	408,723	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	92,374	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	72,073	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	64,602	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	359,142	0	0	0	57.00
58.00	05800	MRI	0.000000	154,119	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,468,699	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	7,261	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	320,381	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	111,774	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	73,233	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	32,354	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	618,614	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	296,380	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	500,714	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,682,114	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	90,168	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	31,781	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	489,836	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	47,051	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		9,737,840	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 4:51 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	0.143691	0	0	5,433,705	0	50.00
51.00	05100	RECOVERY ROOM	0.229729	0	0	1,065,688	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.664536	0	0	55,854	0	52.00
53.00	05300	ANESTHESIOLOGY	0.201042	0	0	1,091,199	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.317712	0	0	820,906	0	54.00
54.01	05401	ULTRASOUND	0.115485	0	0	1,239,576	0	54.01
56.00	05600	RADIOISOTOPE	0.066753	0	0	240,691	0	56.00
57.00	05700	CT SCAN	0.046521	0	0	1,732,579	0	57.00
58.00	05800	MRI	0.153622	0	0	550,002	0	58.00
60.00	06000	LABORATORY	0.141255	0	0	5,166,977	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.274325	0	0	2,789	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.221682	0	0	72,583	0	65.00
66.00	06600	PHYSICAL THERAPY	0.591588	0	0	1,536,009	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.210225	0	0	637,861	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.336238	0	0	1,450,195	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.269309	0	0	1,199,481	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.433711	0	0	460,025	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.392143	0	0	714,585	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142969	0	0	2,900,630	0	73.00
74.00	07400	RENAL DIALYSIS	0.300699	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.144545	0	0	265,497	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.165532	0	0	5,269,729	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.583569	0	0	224,471	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	32,131,032	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	32,131,032	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 4:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	780,775	50.00
51.00	05100	RECOVERY ROOM	0	244,819	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	37,117	52.00
53.00	05300	ANESTHESIOLOGY	0	219,377	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	260,812	54.00
54.01	05401	ULTRASOUND	0	143,152	54.01
56.00	05600	RADIOISOTOPE	0	16,067	56.00
57.00	05700	CT SCAN	0	80,601	57.00
58.00	05800	MRI	0	84,492	58.00
60.00	06000	LABORATORY	0	729,861	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	765	62.00
65.00	06500	RESPIRATORY THERAPY	0	16,090	65.00
66.00	06600	PHYSICAL THERAPY	0	908,684	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	134,094	67.00
68.00	06800	SPEECH PATHOLOGY	0	487,611	68.00
69.00	06900	ELECTROCARDIOLOGY	0	323,031	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	199,518	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	280,220	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	414,700	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	76.00
76.01	03610	SLEEP LAB	0	38,376	76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	872,309	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	130,994	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	6,403,465	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	6,403,465	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0006	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/30/2019 4:51 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)	14,567	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,567	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	13,222	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)	7,380	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)	18,106,179	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)	18,106,179	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)	18,106,179	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)	1,242.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	9,173,045	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)	9,173,045	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 4:51 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	6,072,963	2,890	2,101.37	1,089	2,288,392	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	13,922,318	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	25,383,755	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)	1,096,798	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	990,292	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,087,090	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	23,296,665	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,345	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,242.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,671,781	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0006	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/30/2019 4:51 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	1,643,680	18,106,179	0.090780	1,671,781	151,764	90.00
91.00	Nursing School cost	0	18,106,179	0.000000	1,671,781	0	91.00
92.00	Allied health cost	0	18,106,179	0.000000	1,671,781	0	92.00
93.00	All other Medical Education	0	18,106,179	0.000000	1,671,781	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 4:51 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)	14,567	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,567	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	13,222	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)	1,086	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,449	15.00
16.00	Nursery days (title V or XIX only)	485	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)	18,106,179	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)	18,106,179	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)	18,106,179	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)	1,242.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,349,855	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,349,855	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 4:51 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,122,677	1,449	774.79	485	375,773	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,072,963	2,890	2,101.37	98	205,934	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,298,911	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,230,473	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)	170,477	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	218,340	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	388,817	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,841,656	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,345	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,242.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,671,781	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 4:51 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	1,643,680	18,106,179	0.090780	1,671,781	151,764	90.00
91.00	Nursing School cost	0	18,106,179	0.000000	1,671,781	0	91.00
92.00	Allied health cost	0	18,106,179	0.000000	1,671,781	0	92.00
93.00	All other Medical Education	0	18,106,179	0.000000	1,671,781	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 4:51 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		17,877,391		30.00
31.00	03100	INTENSIVE CARE UNIT		4,205,025		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.143691	8,510,570	1,222,892	50.00
51.00	05100	RECOVERY ROOM	0.229729	595,307	136,759	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.664536	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.201042	1,780,167	357,888	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.317712	1,098,212	348,915	54.00
54.01	05401	ULTRASOUND	0.115485	540,041	62,367	54.01
56.00	05600	RADIOISOTOPE	0.066753	580,185	38,729	56.00
57.00	05700	CT SCAN	0.046521	3,218,696	149,737	57.00
58.00	05800	MRI	0.153622	749,485	115,137	58.00
60.00	06000	LABORATORY	0.141255	9,880,272	1,395,638	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.274325	178,654	49,009	62.00
65.00	06500	RESPIRATORY THERAPY	0.221682	3,268,257	724,514	65.00
66.00	06600	PHYSICAL THERAPY	0.591588	1,329,535	786,537	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.210225	1,232,702	259,145	67.00
68.00	06800	SPEECH PATHOLOGY	0.336238	368,983	124,066	68.00
69.00	06900	ELECTROCARDIOLOGY	0.269309	5,855,349	1,576,898	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.433711	2,454,504	1,064,545	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.392143	5,776,379	2,265,167	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142969	14,073,696	2,012,102	73.00
74.00	07400	RENAL DIALYSIS	0.300699	1,091,416	328,188	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.144545	125,396	18,125	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.165532	3,928,740	650,332	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.583569	403,770	235,628	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)		67,040,316	13,922,318	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)		67,040,316		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 4:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,926,167		30.00
31.00	03100	INTENSIVE CARE UNIT		422,952		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		420,785		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.143691	1,760,990	253,038	50.00
51.00	05100	RECOVERY ROOM	0.229729	149,855	34,426	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.664536	905,602	601,805	52.00
53.00	05300	ANESTHESIOLOGY	0.201042	408,723	82,170	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.317712	92,374	29,348	54.00
54.01	05401	ULTRASOUND	0.115485	72,073	8,323	54.01
56.00	05600	RADIOISOTOPE	0.066753	64,602	4,312	56.00
57.00	05700	CT SCAN	0.046521	359,142	16,708	57.00
58.00	05800	MRI	0.153622	154,119	23,676	58.00
60.00	06000	LABORATORY	0.141255	1,468,699	207,461	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.274325	7,261	1,992	62.00
65.00	06500	RESPIRATORY THERAPY	0.221682	320,381	71,023	65.00
66.00	06600	PHYSICAL THERAPY	0.591588	111,774	66,124	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.210225	73,233	15,395	67.00
68.00	06800	SPEECH PATHOLOGY	0.336238	32,354	10,879	68.00
69.00	06900	ELECTROCARDIOLOGY	0.269309	618,614	166,598	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.433711	296,380	128,543	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.392143	500,714	196,351	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142969	1,682,114	240,490	73.00
74.00	07400	RENAL DIALYSIS	0.300699	90,168	27,113	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.144545	31,781	4,594	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.165532	489,836	81,084	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.583569	47,051	27,458	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)		9,737,840	2,298,911	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)		9,737,840		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 4:51 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	12,238,839	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,659,133	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)	775,353	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	3,784,024	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	125.32	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.87	30.00
31.00	Percentage of Medicaid patient days (see instructions)	24.24	31.00
32.00	Sum of lines 30 and 31	29.11	32.00
33.00	Allowable disproportionate share percentage (see instructions)	13.23	33.00
34.00	Disproportionate share adjustment (see instructions)	525,826	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Date/Time Prepared: 5/30/2019 4:51 pm

		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,056,133	1,506,287	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	789,929	379,667	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,169,596		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	18,368,747		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)	18,368,747	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,410,130	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	19,778,877	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	19,778,877	61.00
62.00	Deductibles billed to program beneficiaries	1,736,112	62.00
63.00	Coinsurance billed to program beneficiaries	36,479	63.00
64.00	Allowable bad debts (see instructions)	12,680	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	8,242	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,680	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	18,014,528	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)	29,495	70.93
70.94	HRR adjustment amount (see instructions)	-168,014	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Date/Time Prepared: 5/30/2019 4:51 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)		45,991	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		17,830,018	71.00
71.01	Sequestration adjustment (see instructions)		356,600	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		17,359,019	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)		114,399	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,955,524	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2019 4:51 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	12,238,839	12,238,839		12,238,839	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,659,133		3,659,133	3,659,133	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	775,353	656,631	118,722	775,353	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	3,784,024	2,660,902	1,123,122	3,784,024	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	0.1323	0.1323	0.1323		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	525,826	404,800	121,026	525,826	11.00
11.01	Uncompensated care payments	36.00	1,169,596	789,929	379,667	1,169,596	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	18,368,747	14,090,199	4,278,548	18,368,747	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	18,368,747	14,090,199	4,278,548	18,368,747	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,410,130	1,054,700	355,430	1,410,130	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			15,144,899	4,633,978	19,778,877	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2019 4:51 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,290,790	965,440	325,350	1,290,790	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	40,989	30,658	10,331	40,989	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	0.0607	0.0607	0.0607		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	78,351	58,602	19,749	78,351	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,410,130	1,054,700	355,430	1,410,130	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	29,495	22,061	7,434	29,495	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	-168,014	-125,665	-42,349	-168,014	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	45,991	45,991	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/30/2019 4:51 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	13,920	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	16,373,257	2.00
3.00	OPPS payments	12,198,848	3.00
4.00	Outlier payment (see instructions)	122,344	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)	13,920	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	78,053	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)	78,053	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)	78,053	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	64,133	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)	13,920	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)	12,321,192	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	5,030	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,201,688	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)	10,128,394	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)	10,128,394	30.00
31.00	Primary payer payments	4,428	31.00
32.00	Subtotal (line 30 minus line 31)	10,123,966	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)	170,685	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	110,945	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	170,685	36.00
37.00	Subtotal (see instructions)	10,234,911	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-53	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)	10,234,964	40.00
40.01	Sequestration adjustment (see instructions)	204,699	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	10,125,793	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-95,528	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: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/30/2019 4:51 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		17,322,719		10,060,293	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/06/2018	36,300	08/06/2018	65,500	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		36,300		65,500	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)		17,359,019		10,125,793	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		114,399		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		95,528	6.02
7.00	Total Medicare program liability (see instructions)		17,473,418		10,030,265	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: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part II | Date/Time Prepared: 5/30/2019 4:51 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: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-3 Part VII Date/Time Prepared: 5/30/2019 4:51 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		6,403,465	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	6,403,465	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	6,403,465	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	9,737,840	32,131,032	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)	9,737,840	32,131,032	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)	9,737,840	32,131,032	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	9,737,840	25,727,567	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	6,403,465	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	6,403,465	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	6,403,465	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	6,403,465	36.00
37.00	REMOVE SETTLEMENT	0	-6,403,465	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: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/30/2019 4:51 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	-971,245	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	48,864,510	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-22,658,348	0	0	0	6.00
7.00	Inventory	3,033,935	0	0	0	7.00
8.00	Prepaid expenses	1,153,982	0	0	0	8.00
9.00	Other current assets	117,415	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)	29,540,249	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,208,801	0	0	0	12.00
13.00	Land improvements	1,513,919	0	0	0	13.00
14.00	Accumulated depreciation	-355,043	0	0	0	14.00
15.00	Buildings	31,965,896	0	0	0	15.00
16.00	Accumulated depreciation	-10,802,413	0	0	0	16.00
17.00	Leasehold improvements	1,117,720	0	0	0	17.00
18.00	Accumulated depreciation	-206,400	0	0	0	18.00
19.00	Fixed equipment	2,235,958	0	0	0	19.00
20.00	Accumulated depreciation	-1,197,499	0	0	0	20.00
21.00	Automobiles and trucks	113,880	0	0	0	21.00
22.00	Accumulated depreciation	-107,553	0	0	0	22.00
23.00	Major movable equipment	14,211,036	0	0	0	23.00
24.00	Accumulated depreciation	-11,165,165	0	0	0	24.00
25.00	Minor equipment depreciable	6,523,060	0	0	0	25.00
26.00	Accumulated depreciation	-4,356,646	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)	30,699,551	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	15,836,899	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	15,836,899	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	76,076,699	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,701,068	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,248,706	0	0	0	38.00
39.00	Payroll taxes payable	-1,164	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	62,496,731	0	0	0	43.00
44.00	Other current liabilities	2,147,391	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	74,592,732	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	74,592,732	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	1,483,967				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)	1,483,967	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	76,076,699	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/30/2019 4:51 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		10,870,618		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-10,870,044				2.00
3.00	Total (sum of line 1 and line 2)		574		0		3.00
4.00	ROUNDING	4		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)		4		0		10.00
11.00	Subtotal (line 3 plus line 10)		578		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		578		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2019 4:51 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	38,824,069		38,824,069	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	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)	38,824,069		38,824,069	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	9,343,092		9,343,092	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	9,343,092		9,343,092	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	48,167,161		48,167,161	17.00
18.00	Ancillary services	143,123,670	283,748,060	426,871,730	18.00
19.00	Outpatient services	9,240,241	32,309,430	41,549,671	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)	200,531,072	316,057,490	516,588,562	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		148,155,441		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)		148,155,441		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0006	Period: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 5/30/2019 4:51 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	516,588,562	1.00
2.00	Less contractual allowances and discounts on patients' accounts	379,929,590	2.00
3.00	Net patient revenues (line 1 minus line 2)	136,658,972	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	148,155,441	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-11,496,469	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	45,871	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	238,092	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	17,548	16.00
17.00	Revenue from sale of drugs to other than patients	11,208	17.00
18.00	Revenue from sale of medical records and abstracts	7,163	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	248,797	22.00
23.00	Governmental appropriations	0	23.00
24.00	TRAINING REVENUE	153,704	24.00
24.01	MISCELLANEOUS NON-PATIENT REVENUE	101,711	24.01
24.02	GAIN/(LOSS) ON THE DISPOSAL OF FA	-316,901	24.02
24.03	OTHER MISCELLANEOUS REVENUE	61,745	24.03
24.04	GRANT INCOME	57,487	24.04
25.00	Total other income (sum of lines 6-24)	626,425	25.00
26.00	Total (line 5 plus line 25)	-10,870,044	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)	-10,870,044	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0006	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/30/2019 4:51 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,290,790	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	40,989	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)	48.88	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)	4.87	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	24.24	8.00
9.00	Sum of lines 7 and 8	29.11	9.00
10.00	Allowable disproportionate share percentage (see instructions)	6.07	10.00
11.00	Disproportionate share adjustment (see instructions)	78,351	11.00
12.00	Total prospective capital payments (see instructions)	1,410,130	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