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: 15-0011	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/26/2018 2:47 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/26/2018 Time: 2:47 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 MARION GENERAL HOSPITAL (15-0011) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 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	-337,020	98,457	0	-278,229	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-15,909	0		18,030	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-352,929	98,457	0	-260,199	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: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 2:38 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 441 WABASH AVENUE	PO Box:			1.00
2.00	City: MARION	State: IN	Zip Code: 46952-	County: GRANT	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	MARION GENERAL HOSPITAL	150011	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	MARION GENERAL HOSPITAL REHAB	15T011	99915	5	07/01/2005	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	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.	374	1,443	0	0	3,352	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	16	8	0	0	57		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 2:38 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		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.	2		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.	1		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.	07/01/2017	06/30/2018	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	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	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	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)				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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 2:38 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 2:38 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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,185,522	0	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.	Y	Y	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.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 2:38 pm

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

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2015	09/30/2015	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: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/26/2018 2:38 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.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/10/2018	Y	10/10/2018	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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0011	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/26/2018 2:38 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2018 2:38 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	80	29,200	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)		80	29,200	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	19	6,935	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)		99	36,135	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	18	6,570		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		117				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

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	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)	7,057	374	14,022			1.00
2.00	HMO and other (see instructions)	2,944	4,795				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	287	65				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)	7,057	374	14,022			7.00
8.00	INTENSIVE CARE UNIT	1,152	0	3,638			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		0	2,031			13.00
14.00	Total (see instructions)	8,209	374	19,691	0.00	700.02	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	2,053	16	2,681	0.00	15.58	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	715.60	27.00
28.00	Observation Bed Days		1,003	2,980			28.00
29.00	Ambulance Trips	1,500					29.00
30.00	Employee discount days (see instruction)			121			30.00
31.00	Employee discount days - IRF			6			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			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: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2018 2:38 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	1,996	84	4,918	1.00
2.00	HMO and other (see instructions)			686	1,131		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	1,996	84	4,918	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	212	0	263	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 11/26/2018 2:38 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	45,360,326	-14,086	45,346,240	1,852,140.00	24.48	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		91,526	0	91,526	544.00	168.25	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)		8,210,459	284,463	8,494,922	470,517.00	18.05	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		9,281,103	0	9,281,103	211,419.00	43.90	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		252,075	0	252,075	1,681.00	149.96	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		15,006,532	0	15,006,532			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		3,467,901	0	3,467,901			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		32,244	0	32,244			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	1,020,052	423	1,020,475	31,591.00	32.30	26.00
27.00	Administrative & General	5.00	8,349,631	-203,071	8,146,560	346,606.00	23.50	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II | Date/Time Prepared: 11/26/2018 2:38 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.)		1,936,768	0	1,936,768	14,886.00	130.11	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	603,322	-28,114	575,208	32,331.00	17.79	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,417,727	0	1,417,727	102,259.00	13.86	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		277,189	0	277,189	21,187.00	13.08	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,273,884	-398,840	875,044	19,778.00	44.24	38.00
39.00	Central Services and Supply	14.00	100,215	8,854	109,069	6,659.00	16.38	39.00
40.00	Pharmacy	15.00	2,549,837	0	2,549,837	67,596.00	37.72	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part III Date/Time Prepared: 11/26/2018 2:38 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)		48,992,010	-14,086	48,977,924	1,990,472.00	24.61	1.00
2.00	Excluded area salaries (see instructions)		8,210,459	284,463	8,494,922	470,517.00	18.05	2.00
3.00	Subtotal salaries (line 1 minus line 2)		40,781,551	-298,549	40,483,002	1,519,955.00	26.63	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,533,178	0	9,533,178	213,100.00	44.74	4.00
5.00	Subtotal wage-related costs (see inst.)		15,038,776	0	15,038,776	0.00	37.15	5.00
6.00	Total (sum of lines 3 thru 5)		65,353,505	-298,549	65,054,956	1,733,055.00	37.54	6.00
7.00	Total overhead cost (see instructions)		17,528,625	-620,748	16,907,877	642,893.00	26.30	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part IV Date/Time Prepared: 11/26/2018 2:38 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,172,303	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	4,160,544	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	134,321	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)	8,047,137	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	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	321,975	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	389,558	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	3,990,055	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	3,265	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	287,519	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	18,506,677	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: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part V Date/Time Prepared: 11/26/2018 2:38 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	9,281,103	18,506,677	1.00
2.00	Hospital	9,281,103	18,506,677	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			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/26/2018 2:38 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)	0.260215	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	20,611,022	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	88,859,306	6.00
7.00	Medicaid cost (line 1 times line 6)	23,122,524	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)	2,511,502	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,511,502	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,803,594	3,313,981	7,117,575	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	989,752	3,313,981	4,303,733	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,143	502	1,645	22.00
23.00	Cost of charity care (line 21 minus line 22)	988,609	3,313,479	4,302,088	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)	7,710,715	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	744,404	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,145,237	27.01
28.00	Non-Medicare bad debt expense (see instructions)	6,565,478	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,109,269	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,411,357	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,922,859	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		13,626,947	13,626,947	-1,038,595	12,588,352	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,020,052	17,371,409	18,391,461	35,760	18,427,221	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,349,631	23,787,621	32,137,252	-93,393	32,043,859	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01	00601	CAFETERIA	0	0	0	1,287,711	1,287,711	6.01
6.02	00602	CAFETERIA	0	0	0	0	0	6.02
7.00	00700	OPERATION OF PLANT	603,322	4,356,771	4,960,093	418,637	5,378,730	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	427,968	427,968	8.00
9.00	00900	HOUSEKEEPING	0	3,024,222	3,024,222	-417,834	2,606,388	9.00
10.00	01000	DIETARY	0	1,835,351	1,835,351	-1,320,712	514,639	10.00
13.00	01300	NURSING ADMINISTRATION	1,273,884	86,851	1,360,735	-398,840	961,895	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100,215	270,242	370,457	8,854	379,311	14.00
15.00	01500	PHARMACY	2,549,837	9,190,386	11,740,223	-8,425,650	3,314,573	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,970,465	1,412,950	8,383,415	-757,541	7,625,874	30.00
31.00	03100	INTENSIVE CARE UNIT	1,896,041	714,012	2,610,053	5,506	2,615,559	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	939,836	730,058	1,669,894	0	1,669,894	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	1,006,852	1,006,852	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,234,562	13,234,562	167,466	13,402,028	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,935,120	2,891,901	5,827,021	-1,065,255	4,761,766	54.00
57.00	05700	CT SCAN	0	0	0	1,011,419	1,011,419	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	505,750	505,750	58.00
59.00	05900	CARDIAC CATHETERIZATION	580,636	1,296,242	1,876,878	35,675	1,912,553	59.00
60.00	06000	LABORATORY	2,230,977	5,835,235	8,066,212	569	8,066,781	60.00
60.01	06001	ONCOLOGY	943,033	608,473	1,551,506	0	1,551,506	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	1,258,173	738,749	1,996,922	13,468	2,010,390	65.00
66.00	06600	PHYSICAL THERAPY	1,524,713	320,681	1,845,394	0	1,845,394	66.00
69.00	06900	ELECTROCARDIOLOGY	710,819	183,641	894,460	90,299	984,759	69.00
69.01	06901	CARDIAC REHAB	124,410	22,205	146,615	38,073	184,688	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,425,650	8,425,650	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	280,047	244,805	524,852	31,224	556,076	90.00
91.00	09100	EMERGENCY	3,798,492	1,298,392	5,096,884	-54,682	5,042,202	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,016,107	175,537	1,191,644	54,682	1,246,326	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,105,810	103,257,243	142,363,053	-6,939	142,356,114	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,552	19,552	31,683	51,235	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	85,260	16,167	101,427	9,937	111,364	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	1,229,458	1,229,458	-1,145,656	83,802	192.05
192.06	19206	UROLOGY	322,463	1,118,210	1,440,673	54,377	1,495,050	192.06
192.08	19211	PARISH NURSING	27,804	15,281	43,085	9,239	52,324	192.08
192.09	19212	BIOTERRORISM GRANT	0	9,039	9,039	28,114	37,153	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	109,709	563,789	673,498	27,837	701,335	192.12
192.14	19210	MGH PHYS PRACT MGMT	944,691	547,074	1,491,765	42,418	1,534,183	192.14
192.15	19215	MGH MARION SURGEONS	490,811	1,915,176	2,405,987	71,710	2,477,697	192.15
192.16	19216	MGH MGH MED ONC	0	1,428,834	1,428,834	0	1,428,834	192.16
192.17	19217	MGH FMC SOUTH	730,386	2,374,525	3,104,911	356,298	3,461,209	192.17
192.18	19218	MGH FAIRM MED ASSOC	94,677	265,062	359,739	307	360,046	192.18
192.19	19219	MGH FMC MARION	254,955	499,584	754,539	37,555	792,094	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	312,388	999,033	1,311,421	616	1,312,037	193.01
193.02	19302	MGH FMC GAS CITY	219,170	637,603	856,773	105,148	961,921	193.02
193.03	19303	MGH HOSPITALISTS	35,105	3,980,179	4,015,284	0	4,015,284	193.03
193.04	19304	MGH MAR FAM PRACT	900,711	2,061,417	2,962,128	0	2,962,128	193.04
193.05	19305	MGH FMC SWAYZEE	73,188	164,770	237,958	48,275	286,233	193.05

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/26/2018 2:38 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	
193.06	19306	MGH PEDIATRIC CTR	231,079	926,333	1,157,412	57,070	1,214,482	193.06
193.07	19307	MGH SPECIALTY PHYS	77,163	251,545	328,708	14,035	342,743	193.07
193.08	19308	MGH FMC CONVERSE	101,422	241,693	343,115	307	343,422	193.08
193.09	19309	MGH UPLAND HEALTH	407,734	1,279,632	1,687,366	6,314	1,693,680	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	503,419	2,181,732	2,685,151	4,928	2,690,079	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	HEART FAILURE CLINIC	0	27,069	27,069	0	27,069	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	259,241	259,241	194.03
194.04	07953	MGH WORK SOLUTIONS	287,742	507,019	794,761	49,531	844,292	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	28,811	107,219	136,030	0	136,030	194.05
194.08	07957	MGH SMMP BLDG	0	313,743	313,743	-67,813	245,930	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	6,069	6,069	0	6,069	194.10
194.11	07960	FAIRMOUNT	0	24,470	24,470	0	24,470	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	1,650	1,650	0	1,650	194.14
194.15	07965	TOBACCO GRANT	15,828	17,075	32,903	5,468	38,371	194.15
200.00		TOTAL (SUM OF LINES 118 through 199)	45,360,326	126,987,245	172,347,571	0	172,347,571	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-35,971	12,552,381		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,945,135	15,482,086		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-12,543,251	19,500,608		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
6.01	00601	CAFETERIA	-13,371	1,274,340		6.01
6.02	00602	CAFETERIA	0	0		6.02
7.00	00700	OPERATION OF PLANT	-154,545	5,224,185		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-3,074	424,894		8.00
9.00	00900	HOUSEKEEPING	-3,616	2,602,772		9.00
10.00	01000	DIETARY	968	515,607		10.00
13.00	01300	NURSING ADMINISTRATION	0	961,895		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-464	378,847		14.00
15.00	01500	PHARMACY	-40,998	3,273,575		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-48,154	7,577,720		30.00
31.00	03100	INTENSIVE CARE UNIT	-232	2,615,327		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	-71,096	1,598,798		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	1,006,852		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,143,981	12,258,047		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-184,952	4,576,814		54.00
57.00	05700	CT SCAN	0	1,011,419		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	505,750		58.00
59.00	05900	CARDIAC CATHETERIZATION	-4,399	1,908,154		59.00
60.00	06000	LABORATORY	-99,602	7,967,179		60.00
60.01	06001	ONCOLOGY	-4,918	1,546,588		60.01
60.02	06002	RADIATION ONCOLOGY	0	0		60.02
65.00	06500	RESPIRATORY THERAPY	-2,817	2,007,573		65.00
66.00	06600	PHYSICAL THERAPY	-92	1,845,302		66.00
69.00	06900	ELECTROCARDIOLOGY	-53,721	931,038		69.00
69.01	06901	CARDIAC REHAB	-7	184,681		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,425,650		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-10,799	545,277		90.00
91.00	09100	EMERGENCY	-165,643	4,876,559		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-59,639	1,186,687		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-17,589,509	124,766,605		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	51,235		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.02	19202	VISITOR MEALS	0	0		192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	111,364		192.03
192.04	19204	LIFELINE	0	0		192.04
192.05	19205	OWNED PROPERTIES	0	83,802		192.05
192.06	19206	UROLOGY	-57,558	1,437,492		192.06
192.08	19211	PARISH NURSING	0	52,324		192.08
192.09	19212	BIOTERRORISM GRANT	0	37,153		192.09
192.10	19214	BREAST PUMPS	0	0		192.10
192.12	19209	LUNG CENTER	-47,041	654,294		192.12
192.14	19210	MGH PHYS PRACT MGMT	-66,568	1,467,615		192.14
192.15	19215	MGH MARION SURGEONS	-110,484	2,367,213		192.15
192.16	19216	MGH MGH MED ONC	0	1,428,834		192.16
192.17	19217	MGH FMC SOUTH	-330,963	3,130,246		192.17
192.18	19218	MGH FAIRM MED ASSOC	-26,464	333,582		192.18
192.19	19219	MGH FMC MARION	-57,508	734,586		192.19
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MGH FMC NORTHWOOD	0	1,312,037		193.01
193.02	19302	MGH FMC GAS CITY	-141,337	820,584		193.02
193.03	19303	MGH HOSPITALISTS	0	4,015,284		193.03
193.04	19304	MGH MAR FAM PRACT	0	2,962,128		193.04
193.05	19305	MGH FMC SWAYZEE	-29,547	256,686		193.05
193.06	19306	MGH PEDIATRIC CTR	-65,154	1,149,328		193.06
193.07	19307	MGH SPECIALTY PHYS	-24,230	318,513		193.07

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
193.08	19308	MGH FMC CONVERSE	0	343,422		193.08
193.09	19309	MGH UPLAND HEALTH	0	1,693,680		193.09
193.10	19310	MGH MGH WOMENS CTR	0	0		193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0		193.11
193.12	19312	OB/GYN	0	2,690,079		193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0		193.15
194.00	07963	HEART FAILURE CLINIC	0	27,069		194.00
194.01	07950	MOW	0	0		194.01
194.02	07951	MENTAL HEALTH	0	0		194.02
194.03	07952	ADVERTISING	0	259,241		194.03
194.04	07953	MGH WORK SOLUTIONS	-106,598	737,694		194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	136,030		194.05
194.08	07957	MGH SMMP BLDG	0	245,930		194.08
194.09	07958	MGH AMBUCARE BLDG	0	0		194.09
194.10	07959	MGH 106 LYONS BLDG	0	6,069		194.10
194.11	07960	FAIRMOUNT	0	24,470		194.11
194.12	07961	GAS CITY	0	0		194.12
194.13	07962	LYONS	0	0		194.13
194.14	07964	WABASH	0	1,650		194.14
194.15	07965	TOBACCO GRANT	0	38,371		194.15
200.00		TOTAL (SUM OF LINES 118 through 199)	-18,652,961	153,694,610		200.00

RECLASSIFICATIONS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 2:38 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - SATELLITE OFFICE RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	11,391	3,627	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	64,602	9,089	2.00
	0		75,993	12,716	
	B - CAFETERIA RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	61,005	1.00
2.00	CAFETERIA	6.01	0	1,287,711	2.00
	0		0	1,348,716	
	C - ADMIN DIRECTOR RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	423	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	8,854	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	255,239	0	3.00
4.00	CARDIAC CATHETERIZATION	59.00	35,675	0	4.00
5.00	RESPIRATORY THERAPY	65.00	13,468	0	5.00
6.00	ELECTROCARDIOLOGY	69.00	59,459	0	6.00
7.00	CARDIAC REHAB	69.01	23,784	0	7.00
8.00	AMBULANCE SERVICES	95.00	54,682	0	8.00
9.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	31,683	0	9.00
10.00	GREAT BEGINNINGS/MATERNAL	192.03	9,937	0	10.00
11.00	PARISH NURSING	192.08	5,468	0	11.00
12.00	BIOTERRORISM GRANT	192.09	28,114	0	12.00
13.00	TOBACCO GRANT	194.15	5,468	0	13.00
	0		532,254	0	
	D - ADVERTISING				
1.00	ADVERTISING	194.03	169,111	90,130	1.00
	0		169,111	90,130	
	E - LEASED PROPERTY				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35,337	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	120,144	2.00
3.00	OPERATION OF PLANT	7.00	0	445,214	3.00
4.00	HOUSEKEEPING	9.00	0	9,796	4.00
5.00	DIETARY	10.00	0	27,435	5.00
6.00	OPERATING ROOM	50.00	0	167,466	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	308,004	7.00
8.00	CT SCAN	57.00	0	21,629	8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	24,391	9.00
10.00	LABORATORY	60.00	0	86,629	10.00
11.00	ELECTROCARDIOLOGY	69.00	0	15,822	11.00
12.00	CARDIAC REHAB	69.01	0	14,289	12.00
13.00	CLINIC	90.00	0	31,224	13.00
14.00	PARISH NURSING	192.08	0	3,771	14.00
15.00	LUNG CENTER	192.12	0	27,837	15.00
16.00	MGH PHYS PRACT MGMT	192.14	0	42,418	16.00
17.00	MGH MARION SURGEONS	192.15	0	71,710	17.00
18.00	MGH FMC SOUTH	192.17	0	352,672	18.00
19.00	MGH FAIRM MED ASSOC	192.18	0	307	19.00
20.00	MGH FMC MARION	192.19	0	37,555	20.00
21.00	MGH WORK SOLUTIONS	194.04	0	49,531	21.00
22.00	UROLOGY	192.06	0	54,377	22.00
23.00	MGH FMC NORTHWOOD	193.01	0	616	23.00
24.00	MGH FMC GAS CITY	193.02	0	105,148	24.00
25.00	MGH FMC SWAYZEE	193.05	0	48,275	25.00
26.00	MGH PEDIATRIC CTR	193.06	0	57,070	26.00
27.00	MGH SPECIALTY PHYS	193.07	0	14,035	27.00
28.00	MGH FMC CONVERSE	193.08	0	307	28.00
29.00	MGH UPLAND HEALTH	193.09	0	6,314	29.00
30.00	OB/GYN	193.12	0	4,928	30.00
	0		0	2,184,251	
	F - PHARMACY RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	8,425,650	1.00
	0		0	8,425,650	
	G - CT/MRI RECLASS				
1.00	CT SCAN	57.00	497,824	490,495	1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	241,631	238,072	2.00
	0		739,455	728,567	
	H - SHORT TERM DISABILITY RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,764	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	5,928	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	24	3.00
4.00	LABORATORY	60.00	0	1,072	4.00
5.00	EMERGENCY	91.00	0	3,298	5.00

RECLASSIFICATIONS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 2:38 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	0		0	14,086	
	I - NURSERY RECLASS				
1.00	NURSERY	43.00	881,175	125,677	1.00
	0		881,175	125,677	
	J - SMMP HOUSEKEEPING RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,895	1.00
2.00	OPERATION OF PLANT	7.00	0	1,537	2.00
3.00	HOUSEKEEPING	9.00	0	338	3.00
4.00	DIETARY	10.00	0	569	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	21,072	5.00
6.00	CT SCAN	57.00	0	1,471	6.00
7.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,656	7.00
8.00	LABORATORY	60.00	0	2,649	8.00
9.00	MGH FMC SOUTH	192.17	0	23,626	9.00
	0		0	67,813	
	K - LAUNDRY RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	427,968	1.00
	0		0	427,968	
	L - PHYSICIAN MEDICAL DIRECTOR RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	20,000	0	1.00
	0		20,000	0	
500.00	Grand Total: Increases		2,417,988	13,425,574	500.00

RECLASSIFICATIONS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 2:38 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - SATELLITE OFFICE RECLASS						
1.00	LABORATORY	60.00	11,391	3,627	0		1.00
2.00	LABORATORY	60.00	64,602	9,089	0		2.00
	0		75,993	12,716			
	B - CAFETERIA RECLASS						
1.00	DIETARY	10.00	0	1,348,716	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	1,348,716			
	C - ADMIN DIRECTOR RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	50,196	0	0		1.00
2.00	OPERATION OF PLANT	7.00	28,114	0	0		2.00
3.00	NURSING ADMINISTRATION	13.00	398,840	0	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	422	0	0		4.00
5.00	EMERGENCY	91.00	54,682	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
	0		532,254	0			
	D - ADVERTISING						
1.00	ADMINISTRATIVE & GENERAL	5.00	169,111	90,130	0		1.00
	0		169,111	90,130			
	E - LEASED PROPERTY						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,038,595	10		1.00
2.00	OWNED PROPERTIES	192.05	0	1,145,656	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
	0		0	2,184,251			
	F - PHARMACY RECLASS						
1.00	PHARMACY	15.00	0	8,425,650	0		1.00
	0		0	8,425,650			
	G - CT/MRI RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	739,455	728,567	0		1.00
2.00		0.00	0	0	0		2.00
	0		739,455	728,567			
	H - SHORT TERM DISABILITY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	3,764	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	5,928	0	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	24	0	0		3.00
4.00	LABORATORY	60.00	1,072	0	0		4.00
5.00	EMERGENCY	91.00	3,298	0	0		5.00
	0		14,086	0			

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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	I - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	881,175	125,677	0		1.00
	0		881,175	125,677			
	J - SMMP HOUSEKEEPING RECLASS						
1.00	MGH SMMP BLDG	194.08	0	67,813	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	0		0	67,813			
	K - LAUNDRY RECLASS						
1.00	HOUSEKEEPING	9.00	0	427,968	0		1.00
	0		0	427,968			
	L - PHYSICIAN MEDICAL DIRECTOR RECLASS						
1.00	MGH FMC SOUTH	192.17	20,000	0	0		1.00
	0		20,000	0			
500.00	Grand Total: Decreases		2,432,074	13,411,488			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/26/2018 2:38 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	4,646,549	0	0	0	0	1.00
2.00	Land Improvements	3,353,531	0	0	0	0	2.00
3.00	Buildings and Fixtures	122,368,873	10,003,796	0	10,003,796	16,947	3.00
4.00	Building Improvements	3,287,381	0	0	0	0	4.00
5.00	Fixed Equipment	1,144,744	2,044,832	0	2,044,832	13,141	5.00
6.00	Movable Equipment	79,662,007	12,667,724	0	12,667,724	15,799,005	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	214,463,085	24,716,352	0	24,716,352	15,829,093	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	214,463,085	24,716,352	0	24,716,352	15,829,093	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	4,646,549	0	1.00
2.00	Land Improvements	3,353,531	0	2.00
3.00	Buildings and Fixtures	132,355,722	0	3.00
4.00	Building Improvements	3,287,381	0	4.00
5.00	Fixed Equipment	3,176,435	0	5.00
6.00	Movable Equipment	76,530,726	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	223,350,344	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	223,350,344	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 11/26/2018 2:38 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	13,626,947	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	13,626,947	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	13,626,947		1.00
3.00	Total (sum of lines 1-2)	0	13,626,947		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/26/2018 2:38 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	223,350,344	0	223,350,344	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	223,350,344	0	223,350,344	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	13,626,947	-1,038,595	1.00
3.00	Total (sum of lines 1-2)	0	0	0	13,626,947	-1,038,595	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-35,971	0	0	0	12,552,381	1.00
3.00	Total (sum of lines 1-2)	-35,971	0	0	0	12,552,381	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/26/2018 2:38 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,536,038			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-9,410	CAFETERIA	6.01	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/26/2018 2:38 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	
33.00	RETURNED CHECK FEE	B	-145	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	PHYSICIAN PRIV APPLIC	B	-5,350	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-56,456	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	CHILD SEAT SAFETY INSPECTION	B	-2,340	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	HEALTH SCREENING FEES - LAB	B	-21,722	LABORATORY	60.00	0	33.04
33.05	HEALTH SCREENING FEES - RAD	B	-12,861	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	MED STAFF OTHER SCREENING-MED STAFF	B	1,450	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	HEALTH SCREENING FEES	B	-4,231	LABORATORY	60.00	0	33.07
33.08	REBATE	B	-92,912	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	RENTAL OF PROVIDER SPACE BY SUPPLIER	B	-1,200	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	RENT SPACE UPLAND	B	-19,691	LABORATORY	60.00	0	33.10
33.11	PAGER RENTAL	B	-1,200	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	SALE OF SCRAP, WASTE, ETC,	B	-4,957	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	PCC MARKETING AG	B	-409	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	EDUCATIONAL WORKSHOP	B	-401	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	OPT HEALTH LINEN SEV	B	-3,074	LAUNDRY & LINEN SERVICE	8.00	0	33.15
33.16	AMBULANCE SVC - ASSISTS	B	-52,500	AMBULANCE SERVICES	95.00	0	33.16
33.17	AMBULANCE SVC - CORONER SVC	B	-496	AMBULANCE SERVICES	95.00	0	33.17
33.18	AMBULANCE SVC - LINEN SERVICES	B	-4,608	AMBULANCE SERVICES	95.00	0	33.18
33.19	AMBULANCE SVC - COMMUNITY EVENT STAF	B	-1,944	AMBULANCE SERVICES	95.00	0	33.19
33.20	CONTRACT ARU OTH ARU MEDICAL DIRECTO	B	-59,825	SUBPROVIDER - IRF	41.00	0	33.20
33.21	SCHOOL PHYS OTH SCHOOL PHYS	B	-13,460	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	CLINICAL STUDY- OTHER	B	-3,960	ONCOLOGY	60.01	0	33.22
33.23	SICK CHILD CARE PROGRAM	B	-1,445	ADULTS & PEDIATRICS	30.00	0	33.23
33.24	ONC. QUAL	B	-800	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	SETTLEMENTS	B	-247	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	UNCLAIMED OTHER 125 MED/CHILD CARE E	B	-14,844	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	UNCLAIMED OTHER MONIES RECOVERED	B	-386	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	VENDING MACHINES	B	-3,961	CAFETERIA	6.01	0	33.28
33.30	CPR TRAIN OTH AHA COMMUNITY	B	-12,685	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	PHYSICIAN RECRUITMENT	A	-1,008,923	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	GAIN ON DISPOSAL	A	-104,725	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	TELEVISION AND RADIO SERVICE	A	-49,201	OPERATION OF PLANT	7.00	0	33.33
33.34	TELEPHONE SERVICE	A	-105,255	OPERATION OF PLANT	7.00	0	33.34
33.35	MISC REV	B	-606	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	MISC REV	B	-577	PHARMACY	15.00	0	33.36
33.37	ENTERTAINMENT EXP	A	-536	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.39	EMPLOYEE USE OF AUTO	A	-2,659	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	DONATIONS	A	-167,434	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	VHA OPPORTUNITY	A	-99	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.41
33.42	VHA OPPORTUNITY	A	-17,644	ADMINISTRATIVE & GENERAL	5.00	0	33.42
33.43	VHA OPPORTUNITY	A	-89	OPERATION OF PLANT	7.00	0	33.43
33.44	VHA OPPORTUNITY	A	-3,616	HOUSEKEEPING	9.00	0	33.44
33.45	VHA OPPORTUNITY	A	968	DIETARY	10.00	0	33.45
33.46	VHA OPPORTUNITY	A	-464	CENTRAL SERVICES & SUPPLY	14.00	0	33.46
33.47	VHA OPPORTUNITY	A	-40,370	PHARMACY	15.00	0	33.47
33.48	VHA OPPORTUNITY	A	-46,709	ADULTS & PEDIATRICS	30.00	0	33.48
33.49	VHA OPPORTUNITY	A	-232	INTENSIVE CARE UNIT	31.00	0	33.49
33.50	VHA OPPORTUNITY	A	-56	SUBPROVIDER - IRF	41.00	0	33.50
33.51	VHA OPPORTUNITY	A	-10,984	OPERATING ROOM	50.00	0	33.51
33.52	VHA OPPORTUNITY	A	-22,091	RADIOLOGY-DIAGNOSTIC	54.00	0	33.52
33.53	VHA OPPORTUNITY	A	-4,399	CARDIAC CATHETERIZATION	59.00	0	33.53
33.54	VHA OPPORTUNITY	A	-33,228	LABORATORY	60.00	0	33.54
33.55	VHA OPPORTUNITY	A	-230	ONCOLOGY	60.01	0	33.55
33.56	VHA OPPORTUNITY	A	-2,799	RESPIRATORY THERAPY	65.00	0	33.56
33.57	VHA OPPORTUNITY	A	-38	PHYSICAL THERAPY	66.00	0	33.57
33.58	VHA OPPORTUNITY	A	-66	ELECTROCARDIOLOGY	69.00	0	33.58
33.59	VHA OPPORTUNITY	A	-7	CARDIAC REHAB	69.01	0	33.59
33.60	VHA OPPORTUNITY	A	-228	CLINIC	90.00	0	33.60
33.61	VHA OPPORTUNITY	A	-643	EMERGENCY	91.00	0	33.61
33.62	VHA OPPORTUNITY	A	-91	AMBULANCE SERVICES	95.00	0	33.62
33.63	FINANCE BANK SERVICE CHARGES	A	-151,119	ADMINISTRATIVE & GENERAL	5.00	0	33.63

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/26/2018 2:38 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	
33.64	FINANCE DISCOUNT PAYMENTS	A	6,646	ADMINISTRATIVE & GENERAL	5.00	0	33.64
33.65	ELIMINATING ENTRIES	A	-66,568	MGH PHYS PRACT MGMT	192.14	0	33.65
33.66	ELIMINATING ENTRIES	A	-106,598	MGH WORK SOLUTIONS	194.04	0	33.66
33.67	ELIMINATING ENTRIES	A	-47,041	LUNG CENTER	192.12	0	33.67
33.68	ELIMINATING ENTRIES	A	-110,484	MGH MARION SURGEONS	192.15	0	33.68
33.71	ELIMINATING ENTRIES	A	-330,963	MGH FMC SOUTH	192.17	0	33.71
33.72	ELIMINATING ENTRIES	A	-26,464	MGH FAIRM MED ASSOC	192.18	0	33.72
33.73	ELIMINATING ENTRIES	A	-57,508	MGH FMC MARION	192.19	0	33.73
33.74	ELIMINATING ENTRIES	A	-141,337	MGH FMC GAS CITY	193.02	0	33.74
33.75	ELIMINATING ENTRIES	A	-29,547	MGH FMC SWAYZEE	193.05	0	33.75
33.76	ELIMINATING ENTRIES	A	-65,154	MGH PEDIATRIC CTR	193.06	0	33.76
33.77	ELIMINATING ENTRIES	A	-57,558	UROLOGY	192.06	0	33.77
33.78	ELIMINATING ENTRIES	A	-24,230	MGH SPECIALTY PHYS	193.07	0	33.78
33.79	LOBBYING COSTS	A	-18,889	ADMINISTRATIVE & GENERAL	5.00	0	33.79
33.80	LOBBYING COSTS	A	-51	PHARMACY	15.00	0	33.80
33.81	LOBBYING COSTS	A	-728	ONCOLOGY	60.01	0	33.81
33.82	LOBBYING COSTS	A	-18	RESPIRATORY THERAPY	65.00	0	33.82
33.83	LOBBYING COSTS	A	-54	PHYSICAL THERAPY	66.00	0	33.83
33.84	OPERATING INTEREST INCOME	B	-35,971	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.84
33.85	ED ON CALL SVC A/C 7000.2512	A	-2,538,823	ADMINISTRATIVE & GENERAL	5.00	0	33.85
33.86	XIX ASSESSMENT FEE A/C 7200.7892	A	-8,332,197	ADMINISTRATIVE & GENERAL	5.00	0	33.86
33.87	SELF INSURANCE EXPENSE	A	-2,945,036	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.87
33.88	PHLEBOTOMY	B	-8,130	LABORATORY	60.00	0	33.88
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-18,652,961				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/26/2018 2:38 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	41.00	SUBPROVIDER - IRF	11,215	11,215	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	53,655	53,655	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1,132,997	1,132,997	0	0	0	3.00
4.00	90.00	CLINIC	10,571	10,571	0	0	0	4.00
5.00	91.00	EMERGENCY	165,000	165,000	0	0	0	5.00
6.00	60.00	LABORATORY	12,600	12,600	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	150,000	150,000	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,536,038	1,536,038	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	41.00	SUBPROVIDER - IRF	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	41.00	SUBPROVIDER - IRF	0	0	0	11,215		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	53,655		2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,132,997		3.00
4.00	90.00	CLINIC	0	0	0	10,571		4.00
5.00	91.00	EMERGENCY	0	0	0	165,000		5.00
6.00	60.00	LABORATORY	0	0	0	12,600		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	150,000		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,536,038		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	12,552,381	12,552,381				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	15,482,086	474,349	15,956,435			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,500,608	2,055,876	2,932,608	24,489,092	24,489,092	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01	00601	CAFETERIA	1,274,340	165,321	0	1,439,661	272,868	6.01
6.02	00602	CAFETERIA	0	0	0	0	0	6.02
7.00	00700	OPERATION OF PLANT	5,224,185	3,336,917	207,064	8,768,166	1,661,883	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	424,894	71,922	0	496,816	94,165	8.00
9.00	00900	HOUSEKEEPING	2,602,772	110,963	0	2,713,735	514,350	9.00
10.00	01000	DIETARY	515,607	227,780	0	743,387	140,899	10.00
13.00	01300	NURSING ADMINISTRATION	961,895	23,690	314,999	1,300,584	246,507	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	378,847	81,112	39,263	499,222	94,621	14.00
15.00	01500	PHARMACY	3,273,575	104,496	917,893	4,295,964	814,240	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,577,720	1,470,360	2,281,776	11,329,856	2,147,416	30.00
31.00	03100	INTENSIVE CARE UNIT	2,615,327	341,058	682,387	3,638,772	689,678	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,598,798	326,251	338,323	2,263,372	428,990	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	1,006,852	0	317,206	1,324,058	250,957	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,258,047	1,172,700	0	13,430,747	2,545,605	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,576,814	704,103	813,645	6,094,562	1,155,139	54.00
57.00	05700	CT SCAN	1,011,419	51,227	179,207	1,241,853	235,376	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	505,750	60,723	86,983	653,456	123,853	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,908,154	171,550	221,860	2,301,564	436,229	59.00
60.00	06000	LABORATORY	7,967,179	445,757	775,367	9,188,303	1,741,514	60.00
60.01	06001	ONCOLOGY	1,546,588	0	339,474	1,886,062	357,477	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	2,007,573	151,638	457,767	2,616,978	496,012	65.00
66.00	06600	PHYSICAL THERAPY	1,845,302	29,987	548,868	2,424,157	459,465	66.00
69.00	06900	ELECTROCARDIOLOGY	931,038	270,736	281,386	1,483,160	281,112	69.00
69.01	06901	CARDIAC REHAB	184,681	44,147	53,347	282,175	53,482	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,425,650	0	0	8,425,650	1,596,964	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	545,277	96,395	100,812	742,484	140,727	90.00
91.00	09100	EMERGENCY	4,876,559	376,831	1,346,513	6,599,903	1,250,919	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,186,687	141,256	385,464	1,713,407	324,752	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	124,766,605	12,507,145	13,622,212	122,387,146	18,555,200	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	51,235	45,236	11,405	107,876	20,446	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	111,364	0	34,269	145,633	27,603	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	83,802	0	0	83,802	15,883	192.05
192.06	19206	UROLOGY	1,437,492	0	116,081	1,553,573	294,458	192.06
192.08	19211	PARISH NURSING	52,324	0	11,977	64,301	12,187	192.08
192.09	19212	BIOTERRORISM GRANT	37,153	0	10,121	47,274	8,960	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	654,294	0	39,493	693,787	131,498	192.12
192.14	19210	MGH PHYS PRACT MGMT	1,467,615	0	340,071	1,807,686	342,622	192.14
192.15	19215	MGH MARION SURGEONS	2,367,213	0	176,683	2,543,896	482,160	192.15
192.16	19216	MGH MGH MED ONC	1,428,834	0	0	1,428,834	270,815	192.16
192.17	19217	MGH FMC SOUTH	3,130,246	0	255,725	3,385,971	641,763	192.17
192.18	19218	MGH FAIRM MED ASSOC	333,582	0	34,082	367,664	69,686	192.18
192.19	19219	MGH FMC MARION	734,586	0	91,779	826,365	156,626	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	1,312,037	0	112,454	1,424,491	269,992	193.01
193.02	19302	MGH FMC GAS CITY	820,584	0	78,897	899,481	170,484	193.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
193.03	19303	MGH HOSPITALISTS	4,015,284	0	12,637	4,027,921	763,436	193.03
193.04	19304	MGH MAR FAM PRACT	2,962,128	0	324,239	3,286,367	622,885	193.04
193.05	19305	MGH FMC SWAYZEE	256,686	0	26,346	283,032	53,645	193.05
193.06	19306	MGH PEDIATRIC CTR	1,149,328	0	83,184	1,232,512	233,605	193.06
193.07	19307	MGH SPECIALTY PHYS	318,513	0	27,777	346,290	65,634	193.07
193.08	19308	MGH FMC CONVERSE	343,422	0	36,510	379,932	72,011	193.08
193.09	19309	MGH UPLAND HEALTH	1,693,680	0	146,776	1,840,456	348,833	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	2,690,079	0	181,221	2,871,300	544,215	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	HEART FAILURE CLINIC	27,069	0	0	27,069	5,131	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	259,241	0	60,877	320,118	60,674	194.03
194.04	07953	MGH WORK SOLUTIONS	737,694	0	103,582	841,276	159,452	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	136,030	0	10,371	146,401	27,748	194.05
194.08	07957	MGH SMMP BLDG	245,930	0	0	245,930	46,613	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	6,069	0	0	6,069	1,150	194.10
194.11	07960	FAIRMOUNT	24,470	0	0	24,470	4,638	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	1,650	0	0	1,650	313	194.14
194.15	07965	TOBACCO GRANT	38,371	0	7,666	46,037	8,726	194.15
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)	153,694,610	12,552,381	15,956,435	153,694,610	24,489,092	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			6.00	6.01	6.02	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
6.01	00601	CAFETERIA	0	1,712,529				6.01
6.02	00602	CAFETERIA	0	1,637,128	1,637,128			6.02
7.00	00700	OPERATION OF PLANT	0	0	39,964	10,470,013		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	115,495	706,476	8.00
9.00	00900	HOUSEKEEPING	0	0	0	178,190	0	9.00
10.00	01000	DIETARY	0	0	0	365,781	0	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	24,588	38,043	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	8,172	130,253	7,619	14.00
15.00	01500	PHARMACY	0	0	83,038	167,804	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	278,990	2,361,179	172,804	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	76,402	547,687	37,251	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	39,767	523,911	19,646	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	35,258	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	222,711	1,883,181	125,125	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	113,432	1,130,685	51,724	54.00
57.00	05700	CT SCAN	0	0	24,431	82,262	20,267	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	5,929	97,512	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	27,587	275,484	8,344	59.00
60.00	06000	LABORATORY	0	0	106,347	715,820	8	60.00
60.01	06001	ONCOLOGY	0	0	0	0	4,239	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	50,462	243,508	4,257	65.00
66.00	06600	PHYSICAL THERAPY	0	0	24,592	48,155	14,180	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	40,700	434,761	5,182	69.00
69.01	06901	CARDIAC REHAB	0	0	6,941	70,893	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	11,488	154,795	3,203	90.00
91.00	09100	EMERGENCY	0	0	169,777	605,135	204,538	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	62,457	226,837	25,456	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,637,128	1,453,033	10,397,371	703,843	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,276	72,642	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	75,401	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	0	192.05
192.06	19206	UROLOGY	0	0	23,219	0	0	192.06
192.08	19211	PARISH NURSING	0	0	1,966	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	1,188	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	0	0	9,840	0	0	192.12
192.14	19210	MGH PHYS PRACT MGMT	0	0	59,885	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	0	34,339	0	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	0	292	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	79	192.18
192.19	19219	MGH FMC MARION	0	0	20,640	0	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	0	187	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	0	591	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	18,544	0	23	193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	5,286	0	85	193.07

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			6.00	6.01	6.02	7.00	8.00	
193.08	19308	MGH FMC CONVERSE	0	0	0	0	67	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	1,193	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	7,073	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	0	116	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	0	839	0	0	194.15
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)	0	1,712,529	1,637,128	10,470,013	706,476	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			9.00	10.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	CAFETERIA						6.01
6.02	00602	CAFETERIA						6.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	3,406,275					9.00
10.00	01000	DIETARY	50,138	1,300,205				10.00
13.00	01300	NURSING ADMINISTRATION	15,668	0	1,625,390			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,341	0	0	818,228		14.00
15.00	01500	PHARMACY	43,871	0	0	0	5,404,917	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	727,006	779,204	431,058	114,551	0	30.00
31.00	03100	INTENSIVE CARE UNIT	200,553	134,036	118,048	28,638	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	175,484	110,609	61,443	8,182	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	54,477	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	463,780	0	344,106	49,094	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	206,821	0	0	24,547	0	54.00
57.00	05700	CT SCAN	9,401	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	62,673	0	42,623	32,729	0	59.00
60.00	06000	LABORATORY	175,484	0	0	49,094	0	60.00
60.01	06001	ONCOLOGY	0	0	0	4,091	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	131,613	0	77,967	45,003	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	37,997	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	84,608	0	62,884	20,456	0	69.00
69.01	06901	CARDIAC REHAB	94,009	0	10,725	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	5,404,917	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	62,673	0	17,751	0	0	90.00
91.00	09100	EMERGENCY	752,078	16,281	262,318	28,638	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	21,936	0	96,501	8,182	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,356,137	1,040,130	1,617,898	413,205	5,404,917	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,267	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	7,492	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	12,535	0	0	0	0	192.05
192.06	19206	UROLOGY	0	0	0	49,094	0	192.06
192.08	19211	PARISH NURSING	6,267	0	0	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	0	0	0	0	0	192.12
192.14	19210	MGH PHYS PRACT MGMT	25,069	0	0	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	0	0	36,820	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	32,729	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	0	192.18
192.19	19219	MGH FMC MARION	0	0	0	16,365	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	8,182	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	16,365	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	36,820	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	20,456	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	0	8,182	0	193.06

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			9.00	10.00	13.00	14.00	15.00	
193.07	19307	MGH SPECIALTY PHYS	0	0	0	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	8,182	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	49,094	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	90,005	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	0	194.00
194.01	07950	MOW	0	125,434	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	134,641	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	32,729	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	0	0	0	0	194.15
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)	3,406,275	1,300,205	1,625,390	818,228	5,404,917	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	CAFETERIA					6.01
6.02	00602	CAFETERIA					6.02
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
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	18,342,064	0	18,342,064		30.00
31.00	03100	INTENSIVE CARE UNIT	5,471,065	0	5,471,065		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	3,631,404	0	3,631,404		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	1,664,750	0	1,664,750		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	19,064,349	0	19,064,349		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,776,910	0	8,776,910		54.00
57.00	05700	CT SCAN	1,613,590	0	1,613,590		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	880,750	0	880,750		58.00
59.00	05900	CARDIAC CATHETERIZATION	3,187,233	0	3,187,233		59.00
60.00	06000	LABORATORY	11,976,570	0	11,976,570		60.00
60.01	06001	ONCOLOGY	2,251,869	0	2,251,869		60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0		60.02
65.00	06500	RESPIRATORY THERAPY	3,665,800	0	3,665,800		65.00
66.00	06600	PHYSICAL THERAPY	3,008,546	0	3,008,546		66.00
69.00	06900	ELECTROCARDIOLOGY	2,412,863	0	2,412,863		69.00
69.01	06901	CARDIAC REHAB	518,225	0	518,225		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,427,531	0	15,427,531		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,133,121	0	1,133,121		90.00
91.00	09100	EMERGENCY	9,889,587	0	9,889,587		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,479,528	0	2,479,528		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,395,755	0	115,395,755		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	208,507	0	208,507		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.02	19202	VISITOR MEALS	75,401	0	75,401		192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	180,728	0	180,728		192.03
192.04	19204	LIFELINE	0	0	0		192.04
192.05	19205	OWNED PROPERTIES	112,220	0	112,220		192.05
192.06	19206	UROLOGY	1,920,344	0	1,920,344		192.06
192.08	19211	PARISH NURSING	84,721	0	84,721		192.08
192.09	19212	BIOTERRORISM GRANT	57,422	0	57,422		192.09
192.10	19214	BREAST PUMPS	0	0	0		192.10
192.12	19209	LUNG CENTER	835,125	0	835,125		192.12
192.14	19210	MGH PHYS PRACT MGMT	2,235,262	0	2,235,262		192.14
192.15	19215	MGH MARION SURGEONS	3,097,215	0	3,097,215		192.15
192.16	19216	MGH MGH MED ONC	1,699,649	0	1,699,649		192.16
192.17	19217	MGH FMC SOUTH	4,060,755	0	4,060,755		192.17
192.18	19218	MGH FAIRM MED ASSOC	437,429	0	437,429		192.18
192.19	19219	MGH FMC MARION	1,019,996	0	1,019,996		192.19
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	MGH FMC NORTHWOOD	1,702,665	0	1,702,665		193.01
193.02	19302	MGH FMC GAS CITY	1,086,517	0	1,086,517		193.02
193.03	19303	MGH HOSPITALISTS	4,791,357	0	4,791,357		193.03
193.04	19304	MGH MAR FAM PRACT	3,946,663	0	3,946,663		193.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
193.05	19305	MGH FMC SWAYZEE	357,133	0	357,133		193.05
193.06	19306	MGH PEDIATRIC CTR	1,492,866	0	1,492,866		193.06
193.07	19307	MGH SPECIALTY PHYS	417,295	0	417,295		193.07
193.08	19308	MGH FMC CONVERSE	460,192	0	460,192		193.08
193.09	19309	MGH UPLAND HEALTH	2,239,576	0	2,239,576		193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0		193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0		193.11
193.12	19312	OB/GYN	3,505,520	0	3,505,520		193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0		193.15
194.00	07963	HEART FAILURE CLINIC	32,200	0	32,200		194.00
194.01	07950	MOW	125,434	0	125,434		194.01
194.02	07951	MENTAL HEALTH	134,641	0	134,641		194.02
194.03	07952	ADVERTISING	387,865	0	387,865		194.03
194.04	07953	MGH WORK SOLUTIONS	1,033,573	0	1,033,573		194.04
194.05	07954	MGH TAYLOR UNIVERSITY	174,149	0	174,149		194.05
194.08	07957	MGH SMMP BLDG	292,543	0	292,543		194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0		194.09
194.10	07959	MGH 106 LYONS BLDG	7,219	0	7,219		194.10
194.11	07960	FAIRMOUNT	29,108	0	29,108		194.11
194.12	07961	GAS CITY	0	0	0		194.12
194.13	07962	LYONS	0	0	0		194.13
194.14	07964	WABASH	1,963	0	1,963		194.14
194.15	07965	TOBACCO GRANT	55,602	0	55,602		194.15
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	153,694,610	0	153,694,610		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	474,349	474,349	474,349		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	2,055,876	2,055,876	87,195	2,143,071	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01	00601	CAFETERIA	0	165,321	165,321	0	23,880	6.01
6.02	00602	CAFETERIA	0	0	0	0	0	6.02
7.00	00700	OPERATION OF PLANT	0	3,336,917	3,336,917	6,155	145,438	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	71,922	71,922	0	8,241	8.00
9.00	00900	HOUSEKEEPING	0	110,963	110,963	0	45,013	9.00
10.00	01000	DIETARY	0	227,780	227,780	0	12,331	10.00
13.00	01300	NURSING ADMINISTRATION	0	23,690	23,690	9,364	21,573	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	81,112	81,112	1,167	8,281	14.00
15.00	01500	PHARMACY	0	104,496	104,496	27,286	71,257	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,470,360	1,470,360	67,829	187,928	30.00
31.00	03100	INTENSIVE CARE UNIT	0	341,058	341,058	20,285	60,356	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	326,251	326,251	10,057	37,543	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	9,429	21,962	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,172,700	1,172,700	0	222,713	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	704,103	704,103	24,187	101,090	54.00
57.00	05700	CT SCAN	0	51,227	51,227	5,327	20,599	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	60,723	60,723	2,586	10,839	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	171,550	171,550	6,595	38,176	59.00
60.00	06000	LABORATORY	0	445,757	445,757	23,049	152,406	60.00
60.01	06001	ONCOLOGY	0	0	0	10,091	31,284	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	151,638	151,638	13,608	43,408	65.00
66.00	06600	PHYSICAL THERAPY	0	29,987	29,987	16,316	40,209	66.00
69.00	06900	ELECTROCARDIOLOGY	0	270,736	270,736	8,365	24,601	69.00
69.01	06901	CARDIAC REHAB	0	44,147	44,147	1,586	4,680	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	139,756	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	96,395	96,395	2,997	12,316	90.00
91.00	09100	EMERGENCY	0	376,831	376,831	40,027	109,473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	141,256	141,256	11,459	28,420	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	12,507,145	12,507,145	404,960	1,623,773	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	45,236	45,236	339	1,789	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	1,019	2,416	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	1,390	192.05
192.06	19206	UROLOGY	0	0	0	3,451	25,769	192.06
192.08	19211	PARISH NURSING	0	0	0	356	1,067	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	301	784	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	0	0	0	1,174	11,508	192.12
192.14	19210	MGH PHYS PRACT MGMT	0	0	0	10,109	29,984	192.14
192.15	19215	MGH MARION SURGEONS	0	0	0	5,252	42,196	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	23,700	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	7,602	56,163	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	1,013	6,098	192.18
192.19	19219	MGH FMC MARION	0	0	0	2,728	13,707	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	3,343	23,628	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	2,345	14,920	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	376	66,811	193.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
193.04	19304	MGH MAR FAM PRACT	0	0	0	9,639	54,511	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	783	4,695	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	0	2,473	20,444	193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	0	826	5,744	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	1,085	6,302	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	4,363	30,528	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	5,387	47,626	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	449	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	1,810	5,310	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	3,079	13,954	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	308	2,428	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	4,079	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	101	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	406	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	27	194.14
194.15	07965	TOBACCO GRANT	0	0	0	228	764	194.15
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	12,552,381	12,552,381	474,349	2,143,071	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			6.00	6.01	6.02	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
6.01	00601	CAFETERIA	0	189,201				6.01
6.02	00602	CAFETERIA	0	180,871	180,871			6.02
7.00	00700	OPERATION OF PLANT	0	0	4,415	3,492,925		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	38,531	118,694	8.00
9.00	00900	HOUSEKEEPING	0	0	0	59,446	0	9.00
10.00	01000	DIETARY	0	0	0	122,029	0	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,717	12,692	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	903	43,454	1,280	14.00
15.00	01500	PHARMACY	0	0	9,174	55,982	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	30,824	787,719	29,033	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	8,441	182,715	6,259	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	4,394	174,783	3,301	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	3,895	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	24,605	628,252	21,022	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	12,532	377,210	8,690	54.00
57.00	05700	CT SCAN	0	0	2,699	27,444	3,405	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	655	32,531	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	3,048	91,905	1,402	59.00
60.00	06000	LABORATORY	0	0	11,749	238,806	1	60.00
60.01	06001	ONCOLOGY	0	0	0	0	712	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	5,575	81,237	715	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,717	16,065	2,382	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	4,497	145,042	871	69.00
69.01	06901	CARDIAC REHAB	0	0	767	23,651	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	1,269	51,642	538	90.00
91.00	09100	EMERGENCY	0	0	18,757	201,880	34,365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	6,900	75,675	4,277	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	180,871	160,533	3,468,691	118,253	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	141	24,234	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	8,330	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	0	192.05
192.06	19206	UROLOGY	0	0	2,565	0	0	192.06
192.08	19211	PARISH NURSING	0	0	217	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	131	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	0	0	1,087	0	0	192.12
192.14	19210	MGH PHYS PRACT MGMT	0	0	6,616	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	0	3,794	0	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	0	49	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	13	192.18
192.19	19219	MGH FMC MARION	0	0	2,280	0	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	0	31	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	0	99	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	2,049	0	4	193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	584	0	14	193.07

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			6.00	6.01	6.02	7.00	8.00	
193.08	19308	MGH FMC CONVERSE	0	0	0	0	11	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	200	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	781	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	0	20	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	0	93	0	0	194.15
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)	0	189,201	180,871	3,492,925	118,694	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			9.00	10.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	CAFETERIA						6.01
6.02	00602	CAFETERIA						6.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	215,422					9.00
10.00	01000	DIETARY	3,171	365,311				10.00
13.00	01300	NURSING ADMINISTRATION	991	0	71,027			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,955	0	0	141,152		14.00
15.00	01500	PHARMACY	2,775	0	0	0	270,970	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,978	218,929	18,836	19,759	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,684	37,659	5,158	4,940	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	11,098	31,077	2,685	1,412	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	2,381	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,331	0	15,037	8,469	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,080	0	0	4,235	0	54.00
57.00	05700	CT SCAN	595	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,964	0	1,863	5,646	0	59.00
60.00	06000	LABORATORY	11,098	0	0	8,469	0	60.00
60.01	06001	ONCOLOGY	0	0	0	706	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	8,324	0	3,407	7,763	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,660	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	5,351	0	2,748	3,529	0	69.00
69.01	06901	CARDIAC REHAB	5,945	0	469	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	270,970	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,964	0	776	0	0	90.00
91.00	09100	EMERGENCY	47,561	4,574	11,463	4,940	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,387	0	4,217	1,412	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	212,252	292,239	70,700	71,280	270,970	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	396	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	327	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	793	0	0	0	0	192.05
192.06	19206	UROLOGY	0	0	0	8,469	0	192.06
192.08	19211	PARISH NURSING	396	0	0	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	0	0	0	0	0	192.12
192.14	19210	MGH PHYS PRACT MGMT	1,585	0	0	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	0	0	6,352	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	5,646	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	0	192.18
192.19	19219	MGH FMC MARION	0	0	0	2,823	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	1,412	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	2,823	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	6,352	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	3,529	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	0	1,412	0	193.06

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			9.00	10.00	13.00	14.00	15.00	
193.07	19307	MGH SPECIALTY PHYS	0	0	0	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	1,412	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	8,469	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	15,527	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	0	194.00
194.01	07950	MOW	0	35,243	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	37,829	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	5,646	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	0	0	0	0	194.15
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)	215,422	365,311	71,027	141,152	270,970	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	CAFETERIA					6.01
6.02	00602	CAFETERIA					6.02
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
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,877,195	0	2,877,195		30.00
31.00	03100	INTENSIVE CARE UNIT	679,555	0	679,555		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	602,601	0	602,601		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	37,667	0	37,667		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,122,129	0	2,122,129		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,245,127	0	1,245,127		54.00
57.00	05700	CT SCAN	111,296	0	111,296		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	107,334	0	107,334		58.00
59.00	05900	CARDIAC CATHETERIZATION	324,149	0	324,149		59.00
60.00	06000	LABORATORY	891,335	0	891,335		60.00
60.01	06001	ONCOLOGY	42,793	0	42,793		60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0		60.02
65.00	06500	RESPIRATORY THERAPY	315,675	0	315,675		65.00
66.00	06600	PHYSICAL THERAPY	109,336	0	109,336		66.00
69.00	06900	ELECTROCARDIOLOGY	465,740	0	465,740		69.00
69.01	06901	CARDIAC REHAB	81,245	0	81,245		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	410,726	0	410,726		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	169,897	0	169,897		90.00
91.00	09100	EMERGENCY	849,871	0	849,871		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	275,003	0	275,003		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,718,674	0	11,718,674		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	72,135	0	72,135		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.02	19202	VISITOR MEALS	8,330	0	8,330		192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	3,762	0	3,762		192.03
192.04	19204	LIFELINE	0	0	0		192.04
192.05	19205	OWNED PROPERTIES	2,183	0	2,183		192.05
192.06	19206	UROLOGY	40,254	0	40,254		192.06
192.08	19211	PARISH NURSING	2,036	0	2,036		192.08
192.09	19212	BIOTERRORISM GRANT	1,216	0	1,216		192.09
192.10	19214	BREAST PUMPS	0	0	0		192.10
192.12	19209	LUNG CENTER	13,769	0	13,769		192.12
192.14	19210	MGH PHYS PRACT MGMT	48,294	0	48,294		192.14
192.15	19215	MGH MARION SURGEONS	57,594	0	57,594		192.15
192.16	19216	MGH MGH MED ONC	23,700	0	23,700		192.16
192.17	19217	MGH FMC SOUTH	69,460	0	69,460		192.17
192.18	19218	MGH FAIRM MED ASSOC	7,124	0	7,124		192.18
192.19	19219	MGH FMC MARION	21,538	0	21,538		192.19
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	MGH FMC NORTHWOOD	28,383	0	28,383		193.01
193.02	19302	MGH FMC GAS CITY	20,119	0	20,119		193.02
193.03	19303	MGH HOSPITALISTS	67,187	0	67,187		193.03
193.04	19304	MGH MAR FAM PRACT	70,601	0	70,601		193.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
193.05	19305	MGH FMC SWAYZEE	9,007	0	9,007		193.05
193.06	19306	MGH PEDIATRIC CTR	26,382	0	26,382		193.06
193.07	19307	MGH SPECIALTY PHYS	7,168	0	7,168		193.07
193.08	19308	MGH FMC CONVERSE	8,810	0	8,810		193.08
193.09	19309	MGH UPLAND HEALTH	43,560	0	43,560		193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0		193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0		193.11
193.12	19312	OB/GYN	68,540	0	68,540		193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0		193.15
194.00	07963	HEART FAILURE CLINIC	449	0	449		194.00
194.01	07950	MOW	35,243	0	35,243		194.01
194.02	07951	MENTAL HEALTH	37,829	0	37,829		194.02
194.03	07952	ADVERTISING	7,901	0	7,901		194.03
194.04	07953	MGH WORK SOLUTIONS	22,699	0	22,699		194.04
194.05	07954	MGH TAYLOR UNIVERSITY	2,736	0	2,736		194.05
194.08	07957	MGH SMMP BLDG	4,079	0	4,079		194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0		194.09
194.10	07959	MGH 106 LYONS BLDG	101	0	101		194.10
194.11	07960	FAIRMOUNT	406	0	406		194.11
194.12	07961	GAS CITY	0	0	0		194.12
194.13	07962	LYONS	0	0	0		194.13
194.14	07964	WABASH	27	0	27		194.14
194.15	07965	TOBACCO GRANT	1,085	0	1,085		194.15
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	12,552,381	0	12,552,381		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			1.00	4.00	5A	5.00	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	368,779					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,936	44,325,765				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	60,400	8,146,560	-24,489,092	129,205,518		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	294,443	6.00
6.01	00601	CAFETERIA	4,857	0	0	1,439,661	4,857	6.01
6.02	00602	CAFETERIA	0	0	0	0	0	6.02
7.00	00700	OPERATION OF PLANT	98,036	575,208	0	8,768,166	98,036	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,113	0	0	496,816	2,113	8.00
9.00	00900	HOUSEKEEPING	3,260	0	0	2,713,735	3,260	9.00
10.00	01000	DIETARY	6,692	0	0	743,387	6,692	10.00
13.00	01300	NURSING ADMINISTRATION	696	875,044	0	1,300,584	696	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,383	109,069	0	499,222	2,383	14.00
15.00	01500	PHARMACY	3,070	2,549,837	0	4,295,964	3,070	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,198	6,338,601	0	11,329,856	43,198	30.00
31.00	03100	INTENSIVE CARE UNIT	10,020	1,895,619	0	3,638,772	10,020	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	9,585	939,836	0	2,263,372	9,585	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	881,175	0	1,324,058	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,453	0	0	13,430,747	34,453	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,686	2,260,243	0	6,094,562	20,686	54.00
57.00	05700	CT SCAN	1,505	497,824	0	1,241,853	1,505	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,784	241,631	0	653,456	1,784	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,040	616,311	0	2,301,564	5,040	59.00
60.00	06000	LABORATORY	13,096	2,153,912	0	9,188,303	13,096	60.00
60.01	06001	ONCOLOGY	0	943,033	0	1,886,062	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	4,455	1,271,641	0	2,616,978	4,455	65.00
66.00	06600	PHYSICAL THERAPY	881	1,524,713	0	2,424,157	881	66.00
69.00	06900	ELECTROCARDIOLOGY	7,954	781,669	0	1,483,160	7,954	69.00
69.01	06901	CARDIAC REHAB	1,297	148,194	0	282,175	1,297	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,425,650	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,832	280,047	0	742,484	2,832	90.00
91.00	09100	EMERGENCY	11,071	3,740,512	0	6,599,903	11,071	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,150	1,070,789	0	1,713,407	4,150	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	367,450	37,841,468	-24,489,092	97,898,054	293,114	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,329	31,683	0	107,876	1,329	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	95,197	0	145,633	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	83,802	0	192.05
192.06	19206	UROLOGY	0	322,463	0	1,553,573	0	192.06
192.08	19211	PARISH NURSING	0	33,272	0	64,301	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	28,114	0	47,274	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	0	109,709	0	693,787	0	192.12
192.14	19210	MGH PHYS PRACT MGMT	0	944,691	0	1,807,686	0	192.14
192.15	19215	MGH MARION SURGEONS	0	490,811	0	2,543,896	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	1,428,834	0	192.16
192.17	19217	MGH FMC SOUTH	0	710,386	0	3,385,971	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	94,677	0	367,664	0	192.18
192.19	19219	MGH FMC MARION	0	254,955	0	826,365	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	312,388	0	1,424,491	0	193.01
193.02	19302	MGH FMC GAS CITY	0	219,170	0	899,481	0	193.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			1.00	4.00	5A	5.00	6.00	
193.03	19303	MGH HOSPITALISTS	0	35,105	0	4,027,921	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	900,711	0	3,286,367	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	73,188	0	283,032	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	231,079	0	1,232,512	0	193.06
193.07	19307	MGH SPECIALTY PHYS	0	77,163	0	346,290	0	193.07
193.08	19308	MGH FMC CONVERSE	0	101,422	0	379,932	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	407,734	0	1,840,456	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	503,419	0	2,871,300	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	HEART FAILURE CLINIC	0	0	0	27,069	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	169,111	0	320,118	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	287,742	0	841,276	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	28,811	0	146,401	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	245,930	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	6,069	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	24,470	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	1,650	0	194.14
194.15	07965	TOBACCO GRANT	0	21,296	0	46,037	0	194.15
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)	12,552,381	15,956,435		24,489,092	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	34.037678	0.359981		0.189536	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		474,349		2,143,071	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.010701		0.016587	0.000000	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: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	CAFETERIA (MEALS SERVED)	CAFETERIA (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			6.01	6.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	CAFETERIA	238,797					6.01
6.02	00602	CAFETERIA	228,283	1,333,960				6.02
7.00	00700	OPERATION OF PLANT	0	32,563	191,550			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	2,113	711,438		8.00
9.00	00900	HOUSEKEEPING	0	0	3,260	0	56,524	9.00
10.00	01000	DIETARY	0	0	6,692	0	832	10.00
13.00	01300	NURSING ADMINISTRATION	0	20,035	696	0	260	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,659	2,383	7,673	1,300	14.00
15.00	01500	PHARMACY	0	67,661	3,070	0	728	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	227,325	43,198	174,018	12,064	30.00
31.00	03100	INTENSIVE CARE UNIT	0	62,254	10,020	37,513	3,328	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	32,403	9,585	19,784	2,912	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	28,729	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	181,469	34,453	126,004	7,696	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	92,426	20,686	52,087	3,432	54.00
57.00	05700	CT SCAN	0	19,907	1,505	20,409	156	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,831	1,784	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	22,478	5,040	8,403	1,040	59.00
60.00	06000	LABORATORY	0	86,653	13,096	8	2,912	60.00
60.01	06001	ONCOLOGY	0	0	0	4,269	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	41,117	4,455	4,287	2,184	65.00
66.00	06600	PHYSICAL THERAPY	0	20,038	881	14,280	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	33,163	7,954	5,218	1,404	69.00
69.01	06901	CARDIAC REHAB	0	5,656	1,297	0	1,560	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	9,361	2,832	3,225	1,040	90.00
91.00	09100	EMERGENCY	0	138,337	11,071	205,974	12,480	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	50,891	4,150	25,635	364	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	228,283	1,183,956	190,221	708,787	55,692	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,040	1,329	0	104	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	10,514	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	208	192.05
192.06	19206	UROLOGY	0	18,919	0	0	0	192.06
192.08	19211	PARISH NURSING	0	1,602	0	0	104	192.08
192.09	19212	BIOTERRORISM GRANT	0	968	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	0	8,018	0	0	0	192.12
192.14	19210	MGH PHYS PRACT MGMT	0	48,795	0	0	416	192.14
192.15	19215	MGH MARION SURGEONS	0	27,980	0	0	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	294	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	80	0	192.18
192.19	19219	MGH FMC MARION	0	16,818	0	0	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	188	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	595	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	0	193.05

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	CAFETERIA (MEALS SERVED)	CAFETERIA (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			6.01	6.02	7.00	8.00	9.00	
193.06	19306	MGH PEDIATRIC CTR	0	15,110	0	23	0	193.06
193.07	19307	MGH SPECIALTY PHYS	0	4,307	0	86	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	67	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	1,201	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	5,763	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	117	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	684	0	0	0	194.15
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,712,529	1,637,128	10,470,013	706,476	3,406,275	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.171485	1.227269	54.659426	0.993025	60.262455	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	189,201	180,871	3,492,925	118,694	215,422	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.792309	0.135590	18.235056	0.166837	3.811160	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: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)		
			10.00	13.00	14.00	15.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	CAFETERIA						6.01
6.02	00602	CAFETERIA						6.02
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	90,243					10.00
13.00	01300	NURSING ADMINISTRATION	0	857,172				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	10,000			14.00
15.00	01500	PHARMACY	0	0	0	100		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,082	227,325	1,400	0		30.00
31.00	03100	INTENSIVE CARE UNIT	9,303	62,254	350	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	7,677	32,403	100	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
43.00	04300	NURSERY	0	28,729	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	181,469	600	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	300	0		54.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	22,478	400	0		59.00
60.00	06000	LABORATORY	0	0	600	0		60.00
60.01	06001	ONCOLOGY	0	0	50	0		60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0		60.02
65.00	06500	RESPIRATORY THERAPY	0	41,117	550	0		65.00
66.00	06600	PHYSICAL THERAPY	0	20,038	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	33,163	250	0		69.00
69.01	06901	CARDIAC REHAB	0	5,656	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	9,361	0	0		90.00
91.00	09100	EMERGENCY	1,130	138,337	350	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	50,891	100	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72,192	853,221	5,050	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.02	19202	VISITOR MEALS	0	0	0	0		192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	3,951	0	0		192.03
192.04	19204	LIFELINE	0	0	0	0		192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0		192.05
192.06	19206	UROLOGY	0	0	600	0		192.06
192.08	19211	PARISH NURSING	0	0	0	0		192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0		192.09
192.10	19214	BREAST PUMPS	0	0	0	0		192.10
192.12	19209	LUNG CENTER	0	0	0	0		192.12
192.14	19210	MGH PHYS PRACT MGMT	0	0	0	0		192.14
192.15	19215	MGH MARION SURGEONS	0	0	450	0		192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0		192.16
192.17	19217	MGH FMC SOUTH	0	0	400	0		192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0		192.18
192.19	19219	MGH FMC MARION	0	0	200	0		192.19
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	100	0		193.01
193.02	19302	MGH FMC GAS CITY	0	0	200	0		193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0		193.03
193.04	19304	MGH MAR FAM PRACT	0	0	450	0		193.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 2:38 pm

		Cost Center Description	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)		
			10.00	13.00	14.00	15.00		
193.05	19305	MGH FMC SWAYZEE	0	0	250	0		193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	100	0		193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	0	0		193.07
193.08	19308	MGH FMC CONVERSE	0	0	100	0		193.08
193.09	19309	MGH UPLAND HEALTH	0	0	600	0		193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0		193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0		193.11
193.12	19312	OB/GYN	0	0	1,100	0		193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0		193.15
194.00	07963	HEART FAILURE CLINIC	0	0	0	0		194.00
194.01	07950	MOW	8,706	0	0	0		194.01
194.02	07951	MENTAL HEALTH	9,345	0	0	0		194.02
194.03	07952	ADVERTISING	0	0	0	0		194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	400	0		194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0		194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0		194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0		194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0		194.10
194.11	07960	FAIRMOUNT	0	0	0	0		194.11
194.12	07961	GAS CITY	0	0	0	0		194.12
194.13	07962	LYONS	0	0	0	0		194.13
194.14	07964	WABASH	0	0	0	0		194.14
194.15	07965	TOBACCO GRANT	0	0	0	0		194.15
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,300,205	1,625,390	818,228	5,404,917		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.407821	1.896224	81.822800	54,049.170000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	365,311	71,027	141,152	270,970		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.048081	0.082862	14.115200	2,709.700000		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: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,342,064		18,342,064	0	18,342,064	30.00
31.00	03100	INTENSIVE CARE UNIT	5,471,065		5,471,065	0	5,471,065	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	3,631,404		3,631,404	0	3,631,404	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	1,664,750		1,664,750	0	1,664,750	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,064,349		19,064,349	0	19,064,349	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,776,910		8,776,910	0	8,776,910	54.00
57.00	05700	CT SCAN	1,613,590		1,613,590	0	1,613,590	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	880,750		880,750	0	880,750	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,187,233		3,187,233	0	3,187,233	59.00
60.00	06000	LABORATORY	11,976,570		11,976,570	0	11,976,570	60.00
60.01	06001	ONCOLOGY	2,251,869		2,251,869	0	2,251,869	60.01
60.02	06002	RADIATION ONCOLOGY	0		0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	3,665,800	0	3,665,800	0	3,665,800	65.00
66.00	06600	PHYSICAL THERAPY	3,008,546	0	3,008,546	0	3,008,546	66.00
69.00	06900	ELECTROCARDIOLOGY	2,412,863		2,412,863	0	2,412,863	69.00
69.01	06901	CARDIAC REHAB	518,225		518,225	0	518,225	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,427,531		15,427,531	0	15,427,531	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,133,121		1,133,121	0	1,133,121	90.00
91.00	09100	EMERGENCY	9,889,587		9,889,587	0	9,889,587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,214,884		3,214,884		3,214,884	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,479,528		2,479,528	0	2,479,528	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	118,610,639	0	118,610,639	0	118,610,639	200.00
201.00		Less Observation Beds	3,214,884		3,214,884		3,214,884	201.00
202.00		Total (see instructions)	115,395,755	0	115,395,755	0	115,395,755	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I | Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,695,810		18,695,810			30.00
31.00	03100	INTENSIVE CARE UNIT	7,015,302		7,015,302			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	3,523,660		3,523,660			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	2,485,994		2,485,994			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,323,423	73,341,499	109,664,922	0.173842	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,980,463	30,128,593	32,109,056	0.273347	0.000000	54.00
57.00	05700	CT SCAN	4,258,757	29,556,073	33,814,830	0.047718	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	292,261	3,172,444	3,464,705	0.254206	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,238,033	6,204,449	9,442,482	0.337542	0.000000	59.00
60.00	06000	LABORATORY	3,870,489	14,159,996	18,030,485	0.664240	0.000000	60.00
60.01	06001	ONCOLOGY	37,074	6,954,062	6,991,136	0.322103	0.000000	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0.000000	0.000000	60.02
65.00	06500	RESPIRATORY THERAPY	2,678,222	6,105,179	8,783,401	0.417355	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,773,768	5,402,379	10,176,147	0.295647	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	3,651,745	8,281,763	11,933,508	0.202192	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	877,054	877,054	0.590870	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,858,170	73,444,158	82,302,328	0.187450	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,022,120	1,022,120	1.108599	0.000000	90.00
91.00	09100	EMERGENCY	11,083,508	59,943,735	71,027,243	0.139237	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,397,506	6,397,506	0.502521	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,705,773	5,705,773	0.434565	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	112,766,679	330,696,783	443,463,462			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	112,766,679	330,696,783	443,463,462			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.173842		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273347		54.00
57.00	05700	CT SCAN	0.047718		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.254206		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.337542		59.00
60.00	06000	LABORATORY	0.664240		60.00
60.01	06001	ONCOLOGY	0.322103		60.01
60.02	06002	RADIATION ONCOLOGY	0.000000		60.02
65.00	06500	RESPIRATORY THERAPY	0.417355		65.00
66.00	06600	PHYSICAL THERAPY	0.295647		66.00
69.00	06900	ELECTROCARDIOLOGY	0.202192		69.00
69.01	06901	CARDIAC REHAB	0.590870		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187450		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1.108599		90.00
91.00	09100	EMERGENCY	0.139237		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.502521		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.434565		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 2:38 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,342,064		18,342,064	0	18,342,064	30.00
31.00	03100	INTENSIVE CARE UNIT	5,471,065		5,471,065	0	5,471,065	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	3,631,404		3,631,404	0	3,631,404	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	1,664,750		1,664,750	0	1,664,750	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,064,349		19,064,349	0	19,064,349	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,776,910		8,776,910	0	8,776,910	54.00
57.00	05700	CT SCAN	1,613,590		1,613,590	0	1,613,590	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	880,750		880,750	0	880,750	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,187,233		3,187,233	0	3,187,233	59.00
60.00	06000	LABORATORY	11,976,570		11,976,570	0	11,976,570	60.00
60.01	06001	ONCOLOGY	2,251,869		2,251,869	0	2,251,869	60.01
60.02	06002	RADIATION ONCOLOGY	0		0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	3,665,800	0	3,665,800	0	3,665,800	65.00
66.00	06600	PHYSICAL THERAPY	3,008,546	0	3,008,546	0	3,008,546	66.00
69.00	06900	ELECTROCARDIOLOGY	2,412,863		2,412,863	0	2,412,863	69.00
69.01	06901	CARDIAC REHAB	518,225		518,225	0	518,225	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,427,531		15,427,531	0	15,427,531	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,133,121		1,133,121	0	1,133,121	90.00
91.00	09100	EMERGENCY	9,889,587		9,889,587	0	9,889,587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,214,884		3,214,884		3,214,884	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,479,528		2,479,528	0	2,479,528	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	118,610,639	0	118,610,639	0	118,610,639	200.00
201.00		Less Observation Beds	3,214,884		3,214,884		3,214,884	201.00
202.00		Total (see instructions)	115,395,755	0	115,395,755	0	115,395,755	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 2:38 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,695,810		18,695,810			30.00
31.00	03100	INTENSIVE CARE UNIT	7,015,302		7,015,302			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	3,523,660		3,523,660			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	2,485,994		2,485,994			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,323,423	73,341,499	109,664,922	0.173842	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,980,463	30,128,593	32,109,056	0.273347	0.000000	54.00
57.00	05700	CT SCAN	4,258,757	29,556,073	33,814,830	0.047718	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	292,261	3,172,444	3,464,705	0.254206	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,238,033	6,204,449	9,442,482	0.337542	0.000000	59.00
60.00	06000	LABORATORY	3,870,489	14,159,996	18,030,485	0.664240	0.000000	60.00
60.01	06001	ONCOLOGY	37,074	6,954,062	6,991,136	0.322103	0.000000	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0.000000	0.000000	60.02
65.00	06500	RESPIRATORY THERAPY	2,678,222	6,105,179	8,783,401	0.417355	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,773,768	5,402,379	10,176,147	0.295647	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	3,651,745	8,281,763	11,933,508	0.202192	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	877,054	877,054	0.590870	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,858,170	73,444,158	82,302,328	0.187450	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,022,120	1,022,120	1.108599	0.000000	90.00
91.00	09100	EMERGENCY	11,083,508	59,943,735	71,027,243	0.139237	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,397,506	6,397,506	0.502521	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,705,773	5,705,773	0.434565	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	112,766,679	330,696,783	443,463,462			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	112,766,679	330,696,783	443,463,462			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 2:38 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	ONCOLOGY	0.000000		60.01
60.02	06002	RADIATION ONCOLOGY	0.000000		60.02
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHAB	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part I Date/Time Prepared: 11/26/2018 2:38 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	2,877,195	0	2,877,195	17,002	169.23	30.00
31.00	INTENSIVE CARE UNIT	679,555		679,555	3,638	186.79	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	602,601	0	602,601	2,681	224.77	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	37,667		37,667	2,031	18.55	43.00
200.00	Total (lines 30 through 199)	4,197,018		4,197,018	25,352		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	7,057	1,194,256	30.00
31.00	INTENSIVE CARE UNIT	1,152	215,182	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	2,053	461,453	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	10,262	1,870,891	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,122,129	109,664,922	0.019351	12,481,967	241,539	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,245,127	32,109,056	0.038778	1,028,087	39,867	54.00
57.00	05700	CT SCAN	111,296	33,814,830	0.003291	2,523,608	8,305	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	107,334	3,464,705	0.030979	140,701	4,359	58.00
59.00	05900	CARDIAC CATHETERIZATION	324,149	9,442,482	0.034329	1,413,655	48,529	59.00
60.00	06000	LABORATORY	891,335	18,030,485	0.049435	1,984,350	98,096	60.00
60.01	06001	ONCOLOGY	42,793	6,991,136	0.006121	23,576	144	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	315,675	8,783,401	0.035940	1,357,610	48,793	65.00
66.00	06600	PHYSICAL THERAPY	109,336	10,176,147	0.010744	1,122,494	12,060	66.00
69.00	06900	ELECTROCARDIOLOGY	465,740	11,933,508	0.039028	1,962,356	76,587	69.00
69.01	06901	CARDIAC REHAB	81,245	877,054	0.092634	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	410,726	82,302,328	0.004990	4,117,863	20,548	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	169,897	1,022,120	0.166220	0	0	90.00
91.00	09100	EMERGENCY	849,871	71,027,243	0.011965	5,255,449	62,881	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	504,296	6,397,506	0.078827	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	7,750,949	406,036,923		33,411,716	661,708	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
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	17,002	0.00	7,057	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,638	0.00	1,152	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	2,681	0.00	2,053	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00
43.00	04300	NURSERY		0	2,031	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	25,352		10,262	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/26/2018 2:38 pm

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	ONCOLOGY	0	0	0	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		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: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	109,664,922	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,109,056	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	33,814,830	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,464,705	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	9,442,482	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	18,030,485	0.000000	60.00
60.01	06001	ONCOLOGY	0	0	0	6,991,136	0.000000	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0.000000	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,783,401	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,176,147	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	11,933,508	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	877,054	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	82,302,328	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,022,120	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	71,027,243	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	6,397,506	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	406,036,923		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/26/2018 2:38 pm

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		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	12,481,967	0	17,463,523	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,028,087	0	8,311,711	0	54.00
57.00	05700	CT SCAN	0.000000	2,523,608	0	8,885,448	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	140,701	0	1,062,823	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,413,655	0	2,597,652	0	59.00
60.00	06000	LABORATORY	0.000000	1,984,350	0	1,961,230	0	60.00
60.01	06001	ONCOLOGY	0.000000	23,576	0	3,005,152	0	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.000000	1,357,610	0	2,038,690	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,122,494	0	46,791	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,962,356	0	2,694,839	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	287,477	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,117,863	0	36,275,292	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	434,000	0	90.00
91.00	09100	EMERGENCY	0.000000	5,255,449	0	12,775,947	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	1,105,235	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		33,411,716	0	98,945,810	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.173842	17,463,523	0	0	3,035,894	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273347	8,311,711	0	0	2,271,981	54.00
57.00	05700	CT SCAN	0.047718	8,885,448	0	0	423,996	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.254206	1,062,823	0	0	270,176	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.337542	2,597,652	0	0	876,817	59.00
60.00	06000	LABORATORY	0.664240	1,961,230	0	0	1,302,727	60.00
60.01	06001	ONCOLOGY	0.322103	3,005,152	0	0	967,968	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.417355	2,038,690	0	0	850,857	65.00
66.00	06600	PHYSICAL THERAPY	0.295647	46,791	0	0	13,834	66.00
69.00	06900	ELECTROCARDIOLOGY	0.202192	2,694,839	0	0	544,875	69.00
69.01	06901	CARDIAC REHAB	0.590870	287,477	0	0	169,862	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187450	36,275,292	0	6,642	6,799,803	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.108599	434,000	0	0	481,132	90.00
91.00	09100	EMERGENCY	0.139237	12,775,947	0	0	1,778,885	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.502521	1,105,235	0	0	555,404	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.434565		0			95.00
200.00		Subtotal (see instructions)		98,945,810	0	6,642	20,344,211	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		98,945,810	0	6,642	20,344,211	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	ONCOLOGY	0	0		60.01
60.02	06002	RADIATION ONCOLOGY	0	0		60.02
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,245		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,245		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,245		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II | Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,122,129	109,664,922	0.019351	62,184	1,203	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,245,127	32,109,056	0.038778	37,561	1,457	54.00
57.00	05700	CT SCAN	111,296	33,814,830	0.003291	50,513	166	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	107,334	3,464,705	0.030979	15,993	495	58.00
59.00	05900	CARDIAC CATHETERIZATION	324,149	9,442,482	0.034329	4,686	161	59.00
60.00	06000	LABORATORY	891,335	18,030,485	0.049435	72,626	3,590	60.00
60.01	06001	ONCOLOGY	42,793	6,991,136	0.006121	532	3	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	315,675	8,783,401	0.035940	99,295	3,569	65.00
66.00	06600	PHYSICAL THERAPY	109,336	10,176,147	0.010744	2,127,900	22,862	66.00
69.00	06900	ELECTROCARDIOLOGY	465,740	11,933,508	0.039028	55,204	2,155	69.00
69.01	06901	CARDIAC REHAB	81,245	877,054	0.092634	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	410,726	82,302,328	0.004990	357,172	1,782	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	169,897	1,022,120	0.166220	0	0	90.00
91.00	09100	EMERGENCY	849,871	71,027,243	0.011965	71,113	851	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,397,506	0.000000	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	7,246,653	406,036,923		2,954,779	38,294	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	ONCOLOGY	0	0	0	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		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: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	109,664,922	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,109,056	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	33,814,830	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,464,705	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	9,442,482	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	18,030,485	0.000000	60.00
60.01	06001	ONCOLOGY	0	0	0	6,991,136	0.000000	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0.000000	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,783,401	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,176,147	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	11,933,508	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	877,054	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	82,302,328	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,022,120	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	71,027,243	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	6,397,506	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	406,036,923		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	62,184	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	37,561	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	50,513	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	15,993	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	4,686	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	72,626	0	0	0	60.00
60.01	06001	ONCOLOGY	0.000000	532	0	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.000000	99,295	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,127,900	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	55,204	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	357,172	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	71,113	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,954,779	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 2:38 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)	17,002	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,002	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)	14,022	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)	7,057	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)	18,342,064	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)	18,342,064	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)	18,342,064	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)	1,078.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,613,233	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	7,613,233	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 2:38 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	5,471,065	3,638	1,503.87	1,152	1,732,458	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)	7,208,836	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	16,554,527	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)	1,409,438	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	661,708	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,071,146	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	14,483,381	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,980	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,078.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,214,884	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 2:38 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	2,877,195	18,342,064	0.156863	3,214,884	504,296	90.00
91.00	Nursing School cost	0	18,342,064	0.000000	3,214,884	0	91.00
92.00	Allied health cost	0	18,342,064	0.000000	3,214,884	0	92.00
93.00	All other Medical Education	0	18,342,064	0.000000	3,214,884	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/26/2018 2:38 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,681	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,681	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)	2,681	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,053	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,631,404	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,631,404	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,631,404	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)	1,354.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,780,789	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,780,789	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	836,111	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,616,900	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)	461,453	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	38,294	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	499,747	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,117,153	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	602,601	3,631,404	0.165942	0	0	90.00
91.00	Nursing School cost	0	3,631,404	0.000000	0	0	91.00
92.00	Allied health cost	0	3,631,404	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,631,404	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 2:38 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	17,002	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,002	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)	14,022	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)	374	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)	2,031	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)	18,342,064	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)	18,342,064	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)	18,342,064	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)	1,078.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	403,479	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)	403,479	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 2:38 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,664,750	2,031	819.67	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,471,065	3,638	1,503.87	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	300,583	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	704,062	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,980	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,078.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,214,884	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 2:38 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,877,195	18,342,064	0.156863	3,214,884	504,296	90.00
91.00	Nursing School cost	0	18,342,064	0.000000	3,214,884	0	91.00
92.00	Allied health cost	0	18,342,064	0.000000	3,214,884	0	92.00
93.00	All other Medical Education	0	18,342,064	0.000000	3,214,884	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/26/2018 2:38 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,681	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,681	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)	2,681	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)	16	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)	2,031	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,631,404	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,631,404	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,631,404	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)	1,354.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	21,672	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)	21,672	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 2:38 pm

Title XIX | Subprovider - IRF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	5,955	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	27,627	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 2:38 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	602,601	3,631,404	0.165942	0	0	90.00
91.00	Nursing School cost	0	3,631,404	0.000000	0	0	91.00
92.00	Allied health cost	0	3,631,404	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,631,404	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 2:38 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		9,043,392		30.00
31.00	03100	INTENSIVE CARE UNIT		2,574,720		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.173842	12,481,967	2,169,890	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273347	1,028,087	281,024	54.00
57.00	05700	CT SCAN	0.047718	2,523,608	120,422	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.254206	140,701	35,767	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.337542	1,413,655	477,168	59.00
60.00	06000	LABORATORY	0.664240	1,984,350	1,318,085	60.00
60.01	06001	ONCOLOGY	0.322103	23,576	7,594	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.417355	1,357,610	566,605	65.00
66.00	06600	PHYSICAL THERAPY	0.295647	1,122,494	331,862	66.00
69.00	06900	ELECTROCARDIOLOGY	0.202192	1,962,356	396,773	69.00
69.01	06901	CARDIAC REHAB	0.590870	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187450	4,117,863	771,893	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.108599	0	0	90.00
91.00	09100	EMERGENCY	0.139237	5,255,449	731,753	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.502521	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		33,411,716	7,208,836	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)		33,411,716		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		2,760,498		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.173842	62,184	10,810	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273347	37,561	10,267	54.00
57.00	05700	CT SCAN	0.047718	50,513	2,410	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.254206	15,993	4,066	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.337542	4,686	1,582	59.00
60.00	06000	LABORATORY	0.664240	72,626	48,241	60.00
60.01	06001	ONCOLOGY	0.322103	532	171	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.417355	99,295	41,441	65.00
66.00	06600	PHYSICAL THERAPY	0.295647	2,127,900	629,107	66.00
69.00	06900	ELECTROCARDIOLOGY	0.202192	55,204	11,162	69.00
69.01	06901	CARDIAC REHAB	0.590870	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187450	357,172	66,952	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.108599	0	0	90.00
91.00	09100	EMERGENCY	0.139237	71,113	9,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.502521	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,954,779	836,111	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,954,779		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 2:38 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		505,156		30.00
31.00	03100	INTENSIVE CARE UNIT		173,586		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.173842	627,370	109,063	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273347	48,034	13,130	54.00
57.00	05700	CT SCAN	0.047718	74,400	3,550	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.254206	3,998	1,016	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.337542	44,099	14,885	59.00
60.00	06000	LABORATORY	0.664240	80,000	53,139	60.00
60.01	06001	ONCOLOGY	0.322103	947	305	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.417355	61,859	25,817	65.00
66.00	06600	PHYSICAL THERAPY	0.295647	19,443	5,748	66.00
69.00	06900	ELECTROCARDIOLOGY	0.202192	46,729	9,448	69.00
69.01	06901	CARDIAC REHAB	0.590870	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187450	169,684	31,807	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.108599	0	0	90.00
91.00	09100	EMERGENCY	0.139237	234,675	32,675	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.502521	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,411,238	300,583	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,411,238		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 2:38 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		21,072		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.173842	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273347	307	84	54.00
57.00	05700	CT SCAN	0.047718	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.254206	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.337542	0	0	59.00
60.00	06000	LABORATORY	0.664240	403	268	60.00
60.01	06001	ONCOLOGY	0.322103	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.417355	764	319	65.00
66.00	06600	PHYSICAL THERAPY	0.295647	15,605	4,614	66.00
69.00	06900	ELECTROCARDIOLOGY	0.202192	0	0	69.00
69.01	06901	CARDIAC REHAB	0.590870	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187450	3,575	670	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.108599	0	0	90.00
91.00	09100	EMERGENCY	0.139237	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.502521	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		20,654	5,955	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)		20,654		202.00

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		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	3,363,475	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	10,842,099	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)	167,898	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	90.84	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.37	30.00
31.00	Percentage of Medicaid patient days (see instructions)	26.09	31.00
32.00	Sum of lines 30 and 31	31.46	32.00
33.00	Allowable disproportionate share percentage (see instructions)	15.17	33.00
34.00	Disproportionate share adjustment (see instructions)	538,747	34.00

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000142355	0.000205554	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	850,925	1,390,922	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	214,480	1,040,333	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,254,813		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	16,167,032		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	15,603,267		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		16,167,032	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,191,056	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)		17,358,088	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		17,358,088	61.00
62.00	Deductibles billed to program beneficiaries		1,925,168	62.00
63.00	Coinsurance billed to program beneficiaries		36,401	63.00
64.00	Allowable bad debts (see instructions)		201,617	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		131,051	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		85,885	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15,527,570	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)		29,496	70.93
70.94	HRR adjustment amount (see instructions)		-4,337	70.94
70.95	Recovery of accelerated depreciation		0	70.95

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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)		132,857	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		15,419,872	71.00
71.01	Sequestration adjustment (see instructions)		308,397	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		15,448,495	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)		-337,020	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		298,692	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/26/2018 2:38 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,363,475	0	3,363,475		3,363,475	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,842,099	0		10,842,099	10,842,099	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	167,898	0	91,293	76,604	167,897	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1517	0.1517	0.1517	0.1517		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	538,747	0	127,560	411,187	538,747	11.00
11.01	Uncompensated care payments	36.00	1,254,813	0	214,480	1,040,333	1,254,813	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	16,167,032	0	3,796,808	12,370,224	16,167,032	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	16,167,032	0	3,796,808	12,370,224	16,167,032	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,191,056	0	291,047	900,009	1,191,056	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/26/2018 2:38 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	4,087,855	13,270,233	17,358,088	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,155,236	0	272,341	882,895	1,155,236	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	35,820	0	18,706	17,114	35,820	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,191,056	0	291,047	900,009	1,191,056	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/26/2018 2:38 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	3,363,475	3,363,475		3,363,475	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,842,099		10,842,099	10,842,099	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	167,898	91,293	76,605	167,898	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1517	0.1517	0.1517		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	538,747	127,560	411,187	538,747	11.00
11.01	Uncompensated care payments	36.00	1,254,813	214,480	1,040,333	1,254,813	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	16,167,032	3,796,808	12,370,224	16,167,032	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	16,167,032	3,796,808	12,370,224	16,167,032	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,191,056	291,047	900,009	1,191,056	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			4,087,855	13,270,233	17,358,088	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/26/2018 2:38 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	1,155,236	272,341	882,895	1,155,236	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	35,820	18,706	17,114	35,820	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,191,056	291,047	900,009	1,191,056	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	29,496	9,695	19,801	29,496	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	-4,337	0	-4,337	-4,337	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	132,857	132,857	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part B Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,245	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	20,344,211	2.00
3.00	OPPS payments	18,322,471	3.00
4.00	Outlier payment (see instructions)	174,022	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,245	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	6,642	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	6,642	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)	6,642	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	5,397	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	1,245	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)	18,496,493	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,665,044	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	14,832,694	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	14,832,694	30.00
31.00	Primary payer payments	1,806	31.00
32.00	Subtotal (line 30 minus line 31)	14,830,888	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)	943,620	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	613,353	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	636,052	36.00
37.00	Subtotal (see instructions)	15,444,241	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-226	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)	15,444,467	40.00
40.01	Sequestration adjustment (see instructions)	308,889	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	15,037,121	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	98,457	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: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/26/2018 2:38 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		15,362,732		14,534,080	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	05/30/2018	85,763	05/30/2018	503,041	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)		85,763		503,041	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)		15,448,495		15,037,121	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		0		98,457	6.01
6.02	SETTLEMENT TO PROGRAM		337,020		0	6.02
7.00	Total Medicare program liability (see instructions)		15,111,475		15,135,578	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/26/2018 2:38 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,372,599		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,372,599		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		15,909		0	6.02
7.00	Total Medicare program liability (see instructions)		3,356,690		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0011	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/26/2018 2:38 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: 15-0011 Component CCN: 15-T011	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part III Date/Time Prepared: 11/26/2018 2:38 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	3,367,582	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0370	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	70,382	3.00
4.00	Outlier Payments	52,050	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	7.345205	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	3,490,014	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	3,490,014	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	3,490,014	19.00
20.00	Deductibles	59,556	20.00
21.00	Subtotal (line 19 minus line 20)	3,430,458	21.00
22.00	Coinsurance	5,264	22.00
23.00	Subtotal (line 21 minus line 22)	3,425,194	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	3,425,194	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	3,425,194	32.00
32.01	Sequestration adjustment (see instructions)	68,504	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	3,372,599	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-15,909	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	42,489	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	52,050	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2018 2:38 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	704,062		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	704,062	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	704,062	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	678,742		8.00
9.00	Ancillary service charges	1,411,238	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	2,089,980	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	2,089,980	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,385,918	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	704,062	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	704,062	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	704,062	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	704,062	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	704,062	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)	704,062	0	40.00
41.00	Interim payments	982,291	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-278,229	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2018 2:38 pm
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	27,627		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	27,627	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	27,627	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	21,072		8.00
9.00	Ancillary service charges	20,654	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	41,726	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	41,726	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	14,099	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	27,627	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	27,627	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	27,627	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	27,627	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	27,627	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)	27,627	0	40.00
41.00	Interim payments	9,597	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	18,030	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: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/26/2018 2:38 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	11,363,807	0	0	0	1.00
2.00	Temporary investments	761,199	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	59,726,520	0	0	0	4.00
5.00	Other receivable	2,257,250	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-37,325,371	0	0	0	6.00
7.00	Inventory	1,266,339	0	0	0	7.00
8.00	Prepaid expenses	2,807,776	0	0	0	8.00
9.00	Other current assets	875,009	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)	41,732,529	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	4,646,549	0	0	0	12.00
13.00	Land improvements	3,353,531	0	0	0	13.00
14.00	Accumulated depreciation	-2,593,444	0	0	0	14.00
15.00	Buildings	132,355,722	0	0	0	15.00
16.00	Accumulated depreciation	-74,557,142	0	0	0	16.00
17.00	Leasehold improvements	3,287,381	0	0	0	17.00
18.00	Accumulated depreciation	-1,966,907	0	0	0	18.00
19.00	Fixed equipment	3,176,435	0	0	0	19.00
20.00	Accumulated depreciation	-815,421	0	0	0	20.00
21.00	Automobiles and trucks	1,030,472	0	0	0	21.00
22.00	Accumulated depreciation	-768,332	0	0	0	22.00
23.00	Major movable equipment	70,648,049	0	0	0	23.00
24.00	Accumulated depreciation	-55,480,752	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	4,852,203	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	87,168,344	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	245,687,872	10,155	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	8,086,712	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	253,774,584	10,155	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	382,675,457	10,155	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,272,977	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,634,142	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,034,023	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,941,142	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	82,017,281	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	82,017,281	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	99,958,423	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	282,717,034				52.00
53.00	Specific purpose fund		10,155			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)	282,717,034	10,155	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	382,675,457	10,155	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/26/2018 2:38 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		265,984,067		10,155		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		16,732,967				2.00
3.00	Total (sum of line 1 and line 2)		282,717,034		10,155		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		282,717,034		10,155		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)		282,717,034		10,155		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/26/2018 2:38 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	21,181,804		21,181,804	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	3,523,660		3,523,660	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	24,705,464		24,705,464	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	7,015,302		7,015,302	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)	7,015,302		7,015,302	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	31,720,766		31,720,766	17.00
18.00	Ancillary services	69,962,405	257,627,649	327,590,054	18.00
19.00	Outpatient services	11,083,508	67,363,361	78,446,869	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	5,705,773	5,705,773	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	30,009,629	30,009,629	27.00
27.01	SELF INSURANCE REVENUE	899,539	3,914,417	4,813,956	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	113,666,218	364,620,829	478,287,047	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		172,347,571		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	ELIMINATING ENTRY	1,063,452			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)		1,063,452		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		171,284,119		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-3 | Date/Time Prepared: 11/26/2018 2:38 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	478,287,047	1.00
2.00	Less contractual allowances and discounts on patients' accounts	306,764,996	2.00
3.00	Net patient revenues (line 1 minus line 2)	171,522,051	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	171,284,119	4.00
5.00	Net income from service to patients (line 3 minus line 4)	237,932	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	18,073,181	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,736,062	24.00
24.01	PENSION	2,491,051	24.01
24.02	UNREALIZED GAIN/LOSS	-5,912,065	24.02
25.00	Total other income (sum of lines 6-24)	16,388,229	25.00
26.00	Total (line 5 plus line 25)	16,626,161	26.00
27.00	BAD DEBT	-106,806	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-106,806	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	16,732,967	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0011	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/26/2018 2:38 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,155,236	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	35,820	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)	48.72	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,191,056	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