

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: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 8:36 am
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/29/2019 Time: 8:36 am
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 MEMORIAL HOSPITAL OF SOUTH BEND, INC ( 15-0058 ) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-489,326	-44,114	0	0	1.00
2.00 Subprovider - IPF	0	5,894	0			2.00
3.00 Subprovider - IRF	0	-34,042	0			3.00
5.00 Swing bed - SNF	0	0	0			5.00
6.00 Swing bed - NF	0					6.00
200.00 Total	0	-517,474	-44,114	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 8:36 am				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 615 N MICHIGAN ST			PO Box:						1.00	
2.00	City: SOUTH BEND			State: IN		Zip Code: 46601		County: ST. JOSEPH		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	V	XVIII	XIX		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		MEMORIAL HOSPITAL OF SOUTH BEND, INC	150058	43780	1	01/01/1984	N	P	P	3.00
4.00	Subprovider - IPF		PSYCHIATRIC UNIT	15S058	43780	4	04/07/2011	N	P	P	4.00
5.00	Subprovider - IRF		REHABILITATION UNIT	15T058	43780	5	01/01/1984	N	P	P	5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:		To:			
						1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2018		12/31/2018		20.00	
21.00	Type of Control (see instructions)					2				21.00	
						1.00		2.00		3.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		N	23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,059	14,926	2,755	0	12,348	0		24.00		

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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	11	173	0	0	302			25.00		
						Urban/Rural	S	Date of Geogr			
						1.00		2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00		
						Beginning:		Ending:			
						1.00		2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00		
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01		
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00		
						Y/N		Y/N			
						1.00		2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N		N	39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N		N	40.00		
						V	XVII	XIX			
						1.00	2.00	3.00			
<b>Prospective Payment System (PPS)-Capital</b>											
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N		Y	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N		N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N		N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N		N	N	48.00	
<b>Teaching Hospitals</b>											
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.							Y		56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							N		57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							N		58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.							N		59.00	
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification 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)							Y		60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)								23.00	1	60.01

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.00	Y			3.00	3.00		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)							
61.01							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)							
61.02							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)							
61.03							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)							
61.04							61.04
Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).							
61.05							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)							
61.06							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)							
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10				0.00	0.00		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.							
61.20				0.00	0.00		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.							
					1.00		
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>							
62.00					0.00		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)							
62.01					0.00		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)							
<b>Teaching Hospitals that Claim Residents in Nonprovider Settings</b>							
63.00					N		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)							
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00				0.00	0.00	0.000000	64.00
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)							

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0058

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

Worksheet S-2  
Part I  
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		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
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				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			
<b>Long Term Care Hospital PPS</b>									
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	
<b>TEFRA Providers</b>									
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		
<b>Title V and XIX Services</b>									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.					N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.					N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.06	
<b>Rural Providers</b>									
105.00	Does this hospital qualify as a CAH?					N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)							106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.							107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					N		108.00	
						Physical	Occupational	Speech	Respiratory
						1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					N	N	N	N
						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: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 8:36 am		
		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			
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	1,081,165	561,275			0118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
<b>Transplant Center Information</b>						
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
<b>All Providers</b>						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		15H013		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0058		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 8:36 am	
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: BEACON HEALTH SYSTEM	Contractor's Name: WI PHYS SVCS		Contractor's Number: 08001		141.00	
142.00	Street: 615 N MICHIGAN ST	PO Box:				142.00	
143.00	City: SOUTH BEND	State: IN		Zip Code: 46601		143.00	
144.00 Are provider based physicians' costs included in Worksheet A?							
						1.00	144.00
						Y	
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.							
						1.00	145.00
						N	
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.							
						1.00	146.00
						N	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							
						1.00	147.00
						N	
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							
						1.00	148.00
						N	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							
						1.00	149.00
						N	
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)							
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
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	
Multi campus							
165.00 Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							
						1.00	165.00
						N	
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)							
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
							0.00
166.00							
167.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
						1.00	167.00
						Y	
168.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							
						1.00	168.00
						0	
168.01 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)							
						1.00	168.01
169.00 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)							
						1.00	169.00
						9.99	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							
						1.00	170.00
						01/01/2018	12/31/2018
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)							
						1.00	171.00
						N	0



HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0058		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 8:36 am	
		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)	Y	12/01/2011			1.00	
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N				2.00	
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N				3.00	
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A			4.00	
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N				5.00	
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N				6.00	
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y				7.00	
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N				8.00	
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y				9.00	
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	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.	Y				11.00	
						Y/N	
						1.00	
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					Y	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16.00	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/11/2019	Y	04/11/2019	17.00	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Y		Y		18.00	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 8:36 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
<b>Cost Report Preparer Contact Information</b>					
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.	JEREMY		KUSKYE	41.00
42.00	Enter the employer/company name of the cost report preparer.	BEACON HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	574-647-1144		JKUSKYE@BEACONHEALTHSYSTEM.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 8:36 am
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT ANALYST		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: 15-0058

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2019 8:36 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	315	114,975	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)		315	114,975	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	46	16,790	0.00	0	8.00
8.01 NEONATAL INTENSIVE CARE UNIT	31.01	30	10,950	0.00	0	8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY					0	13.00
14.00 Total (see instructions)		391	142,715	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	24	8,760		0	16.00
17.00 SUBPROVIDER - IRF	41.00	20	7,300		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		435				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)		9	3,285			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0058

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2019 8:36 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	23,916	2,501	73,367			1.00
2.00 HMO and other (see instructions)	11,462	29,665				2.00
3.00 HMO IPF Subprovider	0	428				3.00
4.00 HMO IRF Subprovider	0	475				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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	23,916	2,501	73,367			7.00
8.00 INTENSIVE CARE UNIT	2,261	0	9,208			8.00
8.01 NEONATAL INTENSIVE CARE UNIT	0	338	8,919			8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		161	4,201			13.00
14.00 Total (see instructions)	26,177	3,000	95,695	27.86	2,308.53	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	993	65	3,090	0.00	21.91	16.00
17.00 SUBPROVIDER - IRF	1,180	11	2,907	0.00	17.37	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			89			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)				27.86	2,347.81	27.00
28.00 Observation Bed Days		0	10,516			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			1,409			30.00
31.00 Employee discount days - IRF			110			31.00
32.00 Labor & delivery days (see instructions)	0	423	735			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: 15-0058

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2019 8:36 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	5,111	536	18,456	1.00
2.00 HMO and other (see instructions)			2,161	4,508		2.00
3.00 HMO IPF Subprovider				49		3.00
4.00 HMO IRF Subprovider				36		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
8.01 NEONATAL INTENSIVE CARE UNIT						8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	5,111	536	18,456	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	80	4	304	16.00
17.00 SUBPROVIDER - IRF	0.00	0	102	1	256	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						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: 15-0058		Period: From 01/01/2018 To 12/31/2018		Worksheet S-3 Part II Date/Time Prepared: 5/29/2019 8:36 am	
	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		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	147,259,041	0	147,259,041	4,883,444.00	30.15	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		1,267,247	0	1,267,247	5,036.00	251.64	4.00
4.01	Physicians - Part A - Teaching		2,279,225	0	2,279,225	19,362.00	117.72	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	1,938,385	1,938,385	56,467.73	34.33	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)		6,821,511	184,925	7,006,436	312,859.00	22.39	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract Labor: Direct Patient Care		5,373,158	0	5,373,158	81,842.00	65.65	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		277,763	0	277,763	1,586.00	175.13	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		14,087,870	0	14,087,870	397,257.00	35.46	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
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		55,763,560	0	55,763,560			17.00
18.00	Wage-related costs (other) (see instructions)		121,779	0	121,779			18.00
19.00	Excluded areas		2,749,736	0	2,749,736			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		309,627	0	309,627			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)		415,090	0	415,090			25.00
25.50	Home office wage-related (core)		6,293,886	0	6,293,886			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
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	230,795	11,558	242,353	23,177.00	10.46	26.00
27.00	Administrative & General	5.00	8,561,016	-2,943,353	5,617,663	184,741.00	30.41	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0058

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/29/2019 8:36 am

		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.)		167,711	0	167,711	492.00	340.88	28.00
29.00	Maintenance & Repairs	6.00	540,450	15,320	555,770	16,791.00	33.10	29.00
30.00	Operation of Plant	7.00	2,631,156	80,466	2,711,622	108,998.00	24.88	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	2,955,255	78,105	3,033,360	187,631.00	16.17	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	3,245,582	-1,256,215	1,989,367	106,910.00	18.61	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,352,307	1,352,307	76,375.00	17.71	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,132,869	82,852	2,215,721	100,514.00	22.04	38.00
39.00	Central Services and Supply	14.00	2,085,423	61,450	2,146,873	103,338.00	20.78	39.00
40.00	Pharmacy	15.00	6,445,212	-6,176,232	268,980	2,080.00	129.32	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	2,944,260	54,830	2,999,090	101,563.00	29.53	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00



HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0058

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/29/2019 8:36 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	145,147,527	-1,938,385	143,209,142	4,808,106.27	29.78	1.00
2.00	Excluded area salaries (see instructions)	6,821,511	184,925	7,006,436	312,859.00	22.39	2.00
3.00	Subtotal salaries (line 1 minus line 2)	138,326,016	-2,123,310	136,202,706	4,495,247.27	30.30	3.00
4.00	Subtotal other wages & related costs (see inst.)	19,738,791	0	19,738,791	480,685.00	41.06	4.00
5.00	Subtotal wage-related costs (see inst.)	62,179,225	0	62,179,225	0.00	45.65	5.00
6.00	Total (sum of lines 3 thru 5)	220,244,032	-2,123,310	218,120,722	4,975,932.27	43.84	6.00
7.00	Total overhead cost (see instructions)	31,939,729	-8,638,912	23,300,817	1,012,610.00	23.01	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2019 8:36 am
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	4,489,336	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	20,459,597	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
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)	22,867,257	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	279,457	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	91,854	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)	459,129	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	99,996	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	10,433,099	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	58,288	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	59,238,013	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	SERVICE AWARDS	121,779	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part V Date/Time Prepared: 5/29/2019 8:36 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 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: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/29/2019 8:36 am
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				1.00		
<b>Uncompensated and indigent care cost computation</b>						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.260022	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			51,514,599	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			18,730,000	5.00	
6.00	Medicaid charges			296,679,296	6.00	
7.00	Medicaid cost (line 1 times line 6)			77,143,144	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			6,898,545	8.00	
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>						
9.00	Net revenue from stand-alone CHIP			6,223	9.00	
10.00	Stand-alone CHIP charges			47,293	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			12,297	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			6,074	12.00	
<b>Other state or local government indigent care program (see instructions for each line)</b>						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			395,545	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			1,923,748	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			500,217	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)			104,672	16.00	
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>						
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)			7,009,291	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
<b>Uncompensated Care (see instructions for each line)</b>						
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	14,012,138	3,366,019	17,378,157	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,643,464	3,366,019	7,009,483	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	187,810	221,925	409,735	22.00	
23.00	Cost of charity care (line 21 minus line 22)	3,455,654	3,144,094	6,599,748	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)			38,194,104	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			891,635	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,371,746	27.01	
28.00	Non-Medicare bad debt expense (see instructions)			36,822,358	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			10,054,734	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			16,654,482	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			23,663,773	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0058

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

Worksheet A  
Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		0	0	21,736,408	21,736,408	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	15,944,557	15,944,557	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	230,795	567,616	798,411	805,200	1,603,611	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,561,016	105,109,385	113,670,401	-38,106,969	75,563,432	5.00
6.00	00600	MAINTENANCE & REPAIRS	540,450	4,272,650	4,813,100	15,320	4,828,420	6.00
7.00	00700	OPERATION OF PLANT	2,631,156	7,450,563	10,081,719	60,545	10,142,264	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,583,352	1,583,352	0	1,583,352	8.00
9.00	00900	HOUSEKEEPING	2,955,255	2,124,268	5,079,523	78,105	5,157,628	9.00
10.00	01000	DIETARY	3,245,582	3,365,782	6,611,364	-2,789,195	3,822,169	10.00
11.00	01100	CAFETERIA	0	0	0	2,754,697	2,754,697	11.00
13.00	01300	NURSING ADMINISTRATION	2,132,869	872,542	3,005,411	82,852	3,088,263	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,085,423	7,728,142	9,813,565	-125,123	9,688,442	14.00
15.00	01500	PHARMACY	6,445,212	33,396,539	39,841,751	-33,289,452	6,552,299	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	2,944,260	987,110	3,931,370	54,830	3,986,200	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,938,385	1,938,385	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,850,850	2,015,182	6,866,032	-1,586,840	5,279,192	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	89,530	50,901	140,431	1,634	142,065	23.00
23.01	02301	PARAMED ED	0	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	33,406,702	16,967,419	50,374,121	181,666	50,555,787	30.00
31.00	03100	INTENSIVE CARE UNIT	6,486,439	4,886,140	11,372,579	-55,228	11,317,351	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	5,933,732	1,927,515	7,861,247	73,380	7,934,627	31.01
40.00	04000	SUBPROVIDER - IPF	1,069,815	374,879	1,444,694	22,869	1,467,563	40.00
41.00	04100	SUBPROVIDER - IRF	1,153,575	427,146	1,580,721	25,610	1,606,331	41.00
43.00	04300	NURSERY	1,352,010	370,788	1,722,798	9,314	1,732,112	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	13,877,915	43,647,806	57,525,721	-24,700,398	32,825,323	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,022,641	3,760,523	7,783,164	-63,504	7,719,660	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,578,548	10,377,156	18,955,704	-4,451,968	14,503,736	54.00
57.00	05700	CT SCAN	1,162,152	695,064	1,857,216	10,346	1,867,562	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,078,626	1,078,626	0	1,078,626	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,174,131	8,292,641	9,466,772	-7,676,880	1,789,892	59.00
60.00	06000	LABORATORY	2,478,126	9,044,619	11,522,745	26,955	11,549,700	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	3,316,845	2,691,804	6,008,649	-198,673	5,809,976	65.00
66.00	06600	PHYSICAL THERAPY	2,656,656	1,101,277	3,757,933	10,700	3,768,633	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	993,726	281,104	1,274,830	12,251	1,287,081	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	398,928	94,602	493,530	16,040	509,570	66.10
67.00	06700	OCCUPATIONAL THERAPY	1,757,517	482,968	2,240,485	20,963	2,261,448	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	248,264	73,146	321,410	4,356	325,766	67.10
68.00	06800	SPEECH PATHOLOGY	968,337	230,129	1,198,466	18,488	1,216,954	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	180,189	46,627	226,816	2,178	228,994	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,311,293	10,311,293	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	26,351,594	26,351,594	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	33,183,975	33,183,975	73.00
76.00	03020	CARDIOLOGY	2,549,013	1,334,672	3,883,685	42,763	3,926,448	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	743,929	249,357	993,286	11,081	1,004,367	90.30
90.50	09004	SLEEP DISORDERS CLINIC	591,808	242,234	834,042	7,236	841,278	90.50
91.00	09100	EMERGENCY	10,937,054	17,825,576	28,762,630	52,819	28,815,449	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	142,750,450	296,027,850	438,778,300	824,180	439,602,480	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
193.00	19300	NONPAID WORKERS	296,192	381,822	678,014	5,717	683,731	193.00
193.10	19301	HEALTH PROPERTIES	2,165,990	1,685,345	3,851,335	114,146	3,965,481	193.10
193.40	19303	LEIGHTON CENTER	0	0	0	0	0	193.40
193.50	19305	WELLNESS CENTER	1,805,910	2,209,311	4,015,221	-953,998	3,061,223	193.50
193.80	19308	UNUSED SPACE	0	0	0	0	0	193.80
193.90	19309	OCCUPATIONAL HEALTH	0	0	0	0	0	193.90
193.91	19310	RESEARCH AND PROTOCOL	0	0	0	0	0	193.91
193.92	19311	CCOP	0	0	0	0	0	193.92
193.93	19312	RESEARCH ADMIN	240,499	63,538	304,037	9,955	313,992	193.93
200.00		TOTAL (SUM OF LINES 118 through 199)	147,259,041	300,367,866	447,626,907	0	447,626,907	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0058

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

Worksheet A  
Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	460,631	22,197,039	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-262,702	15,681,855	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	18,608,144	20,211,755	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-19,994,332	55,569,100	5.00
6.00	00600	MAINTENANCE & REPAIRS	-286,217	4,542,203	6.00
7.00	00700	OPERATION OF PLANT	-585,839	9,556,425	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,583,352	8.00
9.00	00900	HOUSEKEEPING	-705	5,156,923	9.00
10.00	01000	DIETARY	-208,784	3,613,385	10.00
11.00	01100	CAFETERIA	-1,895,652	859,045	11.00
13.00	01300	NURSING ADMINISTRATION	-31,015	3,057,248	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-113,115	9,575,327	14.00
15.00	01500	PHARMACY	0	6,552,299	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,986,200	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,938,385	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	-11,948	5,267,244	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	-3,356	138,709	23.00
23.01	02301	PARAMED ED	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-438,631	50,117,156	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,326,353	9,990,998	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	-340,472	7,594,155	31.01
40.00	04000	SUBPROVIDER - I PF	0	1,467,563	40.00
41.00	04100	SUBPROVIDER - I RF	0	1,606,331	41.00
43.00	04300	NURSERY	0	1,732,112	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-3,313,910	29,511,413	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,390,442	6,329,218	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-350,743	14,152,993	54.00
57.00	05700	CT SCAN	-29,325	1,838,237	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,078,626	58.00
59.00	05900	CARDIAC CATHETERIZATION	-16,378	1,773,514	59.00
60.00	06000	LABORATORY	-3,838	11,545,862	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	5,809,976	65.00
66.00	06600	PHYSICAL THERAPY	-254,964	3,513,669	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	1,287,081	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	509,570	66.10
67.00	06700	OCCUPATIONAL THERAPY	-107,158	2,154,290	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	325,766	67.10
68.00	06800	SPEECH PATHOLOGY	0	1,216,954	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	228,994	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,311,293	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	26,351,594	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-307,262	32,876,713	73.00
76.00	03020	CARDIOLOGY	-189,599	3,736,849	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	-3,498	1,000,869	90.30
90.50	09004	SLEEP DISORDERS CLINIC	-18,858	822,420	90.50
91.00	09100	EMERGENCY	-9,035,156	19,780,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-21,451,477	418,151,003	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
193.00	19300	NONPAID WORKERS	0	683,731	193.00
193.10	19301	HEALTH PROPERTIES	0	3,965,481	193.10
193.40	19303	LEIGHTON CENTER	0	0	193.40
193.50	19305	WELLNESS CENTER	0	3,061,223	193.50
193.80	19308	UNUSED SPACE	0	0	193.80
193.90	19309	OCCUPATIONAL HEALTH	0	0	193.90
193.91	19310	RESEARCH AND PROTOCOL	0	0	193.91
193.92	19311	CCOP	0	0	193.92
193.93	19312	RESEARCH ADMIN	0	313,992	193.93
200.00		TOTAL (SUM OF LINES 118 through 199)	-21,451,477	426,175,430	200.00

RECLASSIFICATIONS

Provider CCN: 15-0058

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

Worksheet A-6  
Date/Time Prepared:  
5/29/2019 8:36 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>A - DRUGS CHARGED TO PATIENTS</b>						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	26,900,728	1.00	
	O		0	26,900,728		
<b>B - SUPPLIES CHARGED TO PATIENTS</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	36,566,419	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
	O		0	36,566,419		
<b>C - AMORTIZATION TO CAPITAL</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	76,898	1.00	
	O		0	76,898		
<b>D - INTEREST TO CAPITAL</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	5,826,771	1.00	
	O		0	5,826,771		
<b>H - EE UTILIZATION OF H&amp;L</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	693,646	1.00	
	O		0	693,646		
<b>I - MEDICAL DIRECTOR RECLASS</b>						
1.00	SUBPROVIDER - IRF	41.00	0	8,519	1.00	
	TOTALS		0	8,519		
<b>O - CAFETERIA FROM DIET SALARIES</b>						
1.00	CAFETERIA	11.00	1,352,307	0	1.00	
	O		1,352,307	0		
<b>R - REBATES</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,583,399	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
	TOTALS		0	1,583,399		
<b>V - MEDICAL DIRECTOR RECLASS</b>						
1.00	ADULTS & PEDIATRICS	30.00	0	17,902	1.00	
	O		0	17,902		
<b>W - WORKERS COMP EH&amp;W</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	99,996	1.00	
	O		0	99,996		
<b>X - PROPERTY INSURANCE TO CAPITAL</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	253,779	1.00	
	O		0	253,779		
<b>Y - GARAGE TO A&amp;G</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	172,598	1.00	
	O		0	172,598		
<b>Z - INCENTIVE</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	11,558	0	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	352,255	0	2.00	
3.00	MAINTENANCE & REPAIRS	6.00	15,320	0	3.00	
4.00	OPERATION OF PLANT	7.00	80,466	0	4.00	
5.00	HOUSEKEEPING	9.00	78,105	0	5.00	
6.00	DIETARY	10.00	96,092	0	6.00	
7.00	NURSING ADMINISTRATION	13.00	82,852	0	7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	61,450	0	8.00	
9.00	PHARMACY	15.00	107,015	0	9.00	
10.00	SOCIAL SERVICE	17.00	54,830	0	10.00	
11.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	370,745	0	11.00	

RECLASSIFICATIONS

Provider CCN: 15-0058

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

Worksheet A-6  
Date/Time Prepared:  
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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
12.00	PARAMED ED PRGM-(SPECIFY)	23.00	1,634	0	12.00
13.00	ADULTS & PEDIATRICS	30.00	591,124	0	13.00
14.00	INTENSIVE CARE UNIT	31.00	91,476	0	14.00
15.00	NEONATAL INTENSIVE CARE UNIT	31.01	76,024	0	15.00
16.00	SUBPROVIDER - IPF	40.00	22,869	0	16.00
17.00	SUBPROVIDER - IRF	41.00	17,424	0	17.00
18.00	NURSERY	43.00	9,800	0	18.00
19.00	OPERATING ROOM	50.00	238,092	0	19.00
20.00	DELIVERY ROOM & LABOR ROOM	52.00	59,310	0	20.00
21.00	RADIOLOGY-DIAGNOSTIC	54.00	246,987	0	21.00
22.00	CT SCAN	57.00	10,346	0	22.00
23.00	CARDIAC CATHETERIZATION	59.00	10,653	0	23.00
24.00	LABORATORY	60.00	61,318	0	24.00
25.00	RESPIRATORY THERAPY	65.00	44,649	0	25.00
26.00	PHYSICAL THERAPY	66.00	47,524	0	26.00
27.00	PHYSICAL THERAPY EAST BANK	66.01	12,251	0	27.00
28.00	PHYSICAL THERAPY LIVING CENTER	66.10	16,040	0	28.00
29.00	OCCUPATIONAL THERAPY	67.00	20,963	0	29.00
30.00	OCCUPATIONAL THERAPY LIVING CENTER	67.10	4,356	0	30.00
31.00	SPEECH PATHOLOGY	68.00	18,488	0	31.00
32.00	SPEECH THERAPY LIVING CENTER	68.10	2,178	0	32.00
33.00	CARDIOLOGY	76.00	66,237	0	33.00
34.00	HEMATOLOGY ONCOLOGY CLINIC	90.30	11,162	0	34.00
35.00	SLEEP DISORDERS CLINIC	90.50	7,623	0	35.00
36.00	EMERGENCY	91.00	153,394	0	36.00
37.00	NONPAID WORKERS	193.00	5,717	0	37.00
38.00	HEALTH PROPERTIES	193.10	55,716	0	38.00
39.00	WELLNESS CENTER	193.50	71,610	0	39.00
40.00	RESEARCH ADMIN	193.93	9,955	0	40.00
	TOTALS		3,295,608	0	
<b>AB - DEPRECIATION TO CAPITAL</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	15,872,310	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	13,978,090	2.00
	O		0	29,850,400	
<b>BA - IMPLANTS CHARGED TO PATIENTS</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	26,351,594	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	O		0	26,351,594	
<b>DA - DACC TP CAPITAL</b>					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	12,767	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	19,921	2.00
3.00		0.00	0	0	3.00
4.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	143,370	4.00
5.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	6,000	5.00
6.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,165,656	6.00
7.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	52,055	7.00
8.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	33,726	8.00
9.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	37,870	9.00
10.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	387	10.00
11.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	48,692	11.00
12.00		0.00	0	0	12.00
13.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	62,322	13.00
14.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	331,962	14.00
15.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	19,200	15.00



RECLASSIFICATIONS

Provider CCN: 15-0058

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

Worksheet A-6

Date/Time Prepared:  
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Increases						
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
16.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	9,069		16.00
17.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	23,470		17.00
			0	1,966,467		
DD - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	5,826,771		1.00
			0	5,826,771		
IR - INTERNS SALARY FROM LN 22 TO LN 21						
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	1,938,385	0		1.00
			1,938,385	0		
OO - CAFETERIA FROM DIET NON-SALARIES						
1.00	CAFETERIA	11.00	0	1,402,390		1.00
			0	1,402,390		
PH - PHARMACY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	6,283,247	0		1.00
			6,283,247	0		
YY - PROPERTIES						
1.00	HEALTH PROPERTIES	193.10	0	293,350		1.00
			0	293,350		
500.00	Grand Total: Increases		12,869,547	137,891,627		500.00

RECLASSIFICATIONS

Provider CCN: 15-0058

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

Worksheet A-6  
Date/Time Prepared:  
5/29/2019 8:36 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - DRUGS CHARGED TO PATIENTS</b>							
1.00	PHARMACY	15.00	0	26,900,728	0		1.00
	O		0	26,900,728			
<b>B - SUPPLIES CHARGED TO PATIENTS</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,526	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	418,291	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	146,704	0		3.00
4.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	2,644	0		4.00
5.00	SUBPROVIDER - IRF	41.00	0	333	0		5.00
6.00	NURSERY	43.00	0	486	0		6.00
7.00	OPERATING ROOM	50.00	0	24,670,787	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	122,814	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,524,590	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	7,403,656	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	205,452	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	15,523	0		12.00
13.00	CARDIOLOGY	76.00	0	4	0		13.00
14.00	HEMATOLOGY ONCOLOGY CLINIC	90.30	0	81	0		14.00
15.00	EMERGENCY	91.00	0	51,883	0		15.00
16.00	PHARMACY	15.00	0	8	0		16.00
17.00	LABORATORY	60.00	0	637	0		17.00
	O		0	36,566,419			
<b>C - AMORTIZATION TO CAPITAL</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	76,898	11		1.00
	O		0	76,898			
<b>D - INTEREST TO CAPITAL</b>							
1.00	INTEREST EXPENSE	113.00	0	5,826,771	11		1.00
	O		0	5,826,771			
<b>H - EE UTILIZATION OF H&amp;L</b>							
1.00	WELLNESS CENTER	193.50	0	693,646	0		1.00
	O		0	693,646			
<b>I - MEDICAL DIRECTOR RECLASS</b>							
1.00	PHYSICAL THERAPY	66.00	0	8,519	0		1.00
	TOTALS		0	8,519			
<b>O - CAFETERIA FROM DIET SALARIES</b>							
1.00	DIETARY	10.00	1,352,307	0	0		1.00
	O		1,352,307	0			
<b>R - REBATES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	781,100	0		1.00
2.00	DIETARY	10.00	0	130,590	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	40,677	0		3.00
4.00	PHARMACY	15.00	0	212,484	0		4.00
5.00	OPERATING ROOM	50.00	0	261,703	0		5.00
6.00	CARDIAC CATHETERIZATION	59.00	0	156,845	0		6.00
	TOTALS		0	1,583,399			
<b>V - MEDICAL DIRECTOR RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,902	0		1.00
	O		0	17,902			
<b>W - WORKERS COMP EH&amp;W</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	99,996	0		1.00
	O		0	99,996			
<b>X - PROPERTY INSURANCE TO CAPITAL</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	253,779	12		1.00
	O		0	253,779			
<b>Y - GARAGE TO A&amp;G</b>							
1.00	HEALTH PROPERTIES	193.10	0	172,598	0		1.00
	O		0	172,598			
<b>Z - INCENTIVE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	3,295,608	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00

RECLASSIFICATIONS

Provider CCN: 15-0058

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

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Date/Time Prepared:  
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		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
17.00		0.00	0	0	0		17.00	
18.00		0.00	0	0	0		18.00	
19.00		0.00	0	0	0		19.00	
20.00		0.00	0	0	0		20.00	
21.00		0.00	0	0	0		21.00	
22.00		0.00	0	0	0		22.00	
23.00		0.00	0	0	0		23.00	
24.00		0.00	0	0	0		24.00	
25.00		0.00	0	0	0		25.00	
26.00		0.00	0	0	0		26.00	
27.00		0.00	0	0	0		27.00	
28.00		0.00	0	0	0		28.00	
29.00		0.00	0	0	0		29.00	
30.00		0.00	0	0	0		30.00	
31.00		0.00	0	0	0		31.00	
32.00		0.00	0	0	0		32.00	
33.00		0.00	0	0	0		33.00	
34.00		0.00	0	0	0		34.00	
35.00		0.00	0	0	0		35.00	
36.00		0.00	0	0	0		36.00	
37.00		0.00	0	0	0		37.00	
38.00		0.00	0	0	0		38.00	
39.00		0.00	0	0	0		39.00	
40.00		0.00	0	0	0		40.00	
TOTALS			3,295,608	0				
AB - DEPRECIATION TO CAPITAL								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	29,850,400		9	1.00	
2.00		0.00	0	0		9	2.00	
0			0	29,850,400				
BA - IMPLANTS CHARGED TO PATIENTS								
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,709		0	1.00	
2.00	CARDIAC CATHETERIZATION	59.00	0	74,977		0	2.00	
3.00	PHYSICAL THERAPY	66.00	0	12,782		0	3.00	
4.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	26,255,126		0	4.00	
0			0	26,351,594				
DA - DACC TP CAPITAL								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,767		10	1.00	
2.00	OPERATION OF PLANT	7.00	0	19,921		10	2.00	
3.00		0.00	0	0		10	3.00	
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	143,370		10	4.00	
5.00	OPERATING ROOM	50.00	0	6,000		10	5.00	
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,165,656		10	6.00	
7.00	CARDIAC CATHETERIZATION	59.00	0	52,055		10	7.00	
8.00	LABORATORY	60.00	0	33,726		10	8.00	
9.00	RESPIRATORY THERAPY	65.00	0	37,870		10	9.00	
10.00	SLEEP DISORDERS CLINIC	90.50	0	387		10	10.00	
11.00	EMERGENCY	91.00	0	48,692		10	11.00	
12.00		0.00	0	0		10	12.00	
13.00	HEALTH PROPERTIES	193.10	0	62,322		10	13.00	
14.00	WELLNESS CENTER	193.50	0	331,962		10	14.00	
15.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	19,200		10	15.00	
16.00	ADULTS & PEDIATRICS	30.00	0	9,069		10	16.00	
17.00	CARDIOLOGY	76.00	0	23,470		10	17.00	
0			0	1,966,467				
DD - INTEREST EXPENSE								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,826,771		0	1.00	
0			0	5,826,771				
IR - INTERNS SALARY FROM LN 22 TO LN 21								
1.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	1,938,385	0		0	1.00	
0			1,938,385	0				
OO - CAFETERIA FROM DIET NON-SALARIES								
1.00	DIETARY	10.00	0	1,402,390		0	1.00	
0			0	1,402,390				
PH - PHARMACY								
1.00	PHARMACY	15.00	6,283,247	0		0	1.00	
0			6,283,247	0				
YY - PROPERTIES								
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	293,350		14	1.00	
0			0	293,350				
500.00	Grand Total: Decreases		12,869,547	137,891,627			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0058

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
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	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	21,318,068	183,342	0	183,342	0 1.00
2.00	Land Improvements	3,426,869	510,218	0	510,218	0 2.00
3.00	Buildings and Fixtures	486,870,628	12,302,756	0	12,302,756	233,205 3.00
4.00	Building Improvements	851,999	0	0	0	0 4.00
5.00	Fixed Equipment	0	0	0	0	0 5.00
6.00	Movable Equipment	293,352,469	8,707,561	0	8,707,561	7,557,452 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	805,820,033	21,703,877	0	21,703,877	7,790,657 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	805,820,033	21,703,877	0	21,703,877	7,790,657 10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	21,501,410	0			1.00
2.00	Land Improvements	3,937,087	2,065,183			2.00
3.00	Buildings and Fixtures	498,940,179	48,671,204			3.00
4.00	Building Improvements	851,999	851,999			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	294,502,578	202,362,771			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	819,733,253	253,951,157			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	819,733,253	253,951,157			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0058

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/29/2019 8:36 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0058

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	525,230,676	0	525,230,676	0.644256	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	294,502,578	4,481,668	290,020,910	0.355744	0	2.00
3.00	Total (sum of lines 1-2)	819,733,254	4,481,668	815,251,586	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	15,614,712	1,519,162	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	13,978,090	4,367,058	2.00
3.00	Total (sum of lines 1-2)	0	0	0	29,592,802	5,886,220	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	5,903,669	253,779	0	-1,094,283	22,197,039	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-990,724	0	0	-1,672,569	15,681,855	2.00
3.00	Total (sum of lines 1-2)	4,912,945	253,779	0	-2,766,852	37,878,894	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0058

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

Worksheet A-8

Date/Time Prepared:  
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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)			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)		0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-72,612	ADMINISTRATIVE & GENERAL	5.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-1,583,399	ADMINISTRATIVE & GENERAL	5.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00		0	7.00
8.00 Television and radio service (chapter 21)		0		0.00		0	8.00
9.00 Parking lot (chapter 21)		0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-15,736,953				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	8,075,183				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-1,617,322	CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others		0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0	16.00
17.00 Sale of drugs to other than patients		0		0.00		0	17.00
18.00 Sale of medical records and abstracts		0		0.00		0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		0	19.00
19.01 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		0	19.01
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		RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			*** Cost Center Deleted ***	19.00		0	28.00
29.00 Physicians' assistant				0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00			30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0058

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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0 32.00
33.00 PENSION ADJUSTMENT	B	18,643,515		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.00
33.01 OTHER REVENUE - MED STAFF OFFICE	B	-17,656		ADMINISTRATIVE & GENERAL	5.00	0 33.01
33.02 OTHER REVENUE - PEDS	B	0		ADULTS & PEDIATRICS	30.00	0 33.02
33.03 OTHER REVENUE - SLEEP CLINIC	B	-31		SLEEP DISORDERS CLINIC	90.50	0 33.03
33.04 OTHER REVENUE - CBU	B	-9,455		DELIVERY ROOM & LABOR ROOM	52.00	0 33.04
33.05 TAXABLE SALES - FCMC	B	-404,102		ADULTS & PEDIATRICS	30.00	0 33.05
33.06 OTHER REVENUE - OTHER ADMIN	B	-429,166		ADMINISTRATIVE & GENERAL	5.00	0 33.06
33.07 OTHER REVENUE - BCC	B	-160		RADIOLOGY-DIAGNOSTIC	54.00	0 33.07
33.08 OTHER REVENUE - CARD NSG ADMIN	B	-8,689		CARDIOLOGY	76.00	0 33.08
33.09 MEDICAL EDUC. CME REVENUE	B			ADMINISTRATIVE & GENERAL	5.00	0 33.09
33.10 CONTRACTED SERVICES	B	-95,042		ADMINISTRATIVE & GENERAL	5.00	0 33.10
33.11 INTEREST INCOME - WORKING CAPITAL	B	-85,679		NEW CAP REL COSTS-MVBLE EQUIP	2.00	11 33.11
33.12 OTHER REVENUE - DISTRIBUTION	B	0		CENTRAL SERVICES & SUPPLY	14.00	0 33.12
33.14 OTHER REVENUE - BIOMED	B	-129,973		MAINTENANCE & REPAIRS	6.00	0 33.14
33.15 PROGRAM MEAL OFFSET	B	-175,206		DIETARY	10.00	0 33.15
33.16 VISITOR MEAL OFFSET	B	-278,330		CAFETERIA	11.00	0 33.16
33.17 OTHER REVENUE - ENGINEERING	B	-46,310		OPERATION OF PLANT	7.00	0 33.17
33.19 OTHER REVENUE - REHAB ADMIN	B	-3,000		PHYSICAL THERAPY	66.00	0 33.19
33.20 OTHER REVENUE - EMPLOYEE BENEFITS	B	-70		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.20
33.22 OTHER REVENUE - RADIOLOGY DIAGN	B	-2,878		RADIOLOGY-DIAGNOSTIC	54.00	0 33.22
33.23 OTHER REVENUE - MED ED	B	0		ADMINISTRATIVE & GENERAL	5.00	0 33.23
33.24 OTHER REVENUE - NICU	B	-256,453		NEONATAL INTENSIVE CARE UNIT	31.01	0 33.24
33.25 OTHER REVENUE-MRI	B			MAGNETIC RESONANCE IMAGING (MRI)	58.00	0 33.25
33.26 OTHER REVENUE - NEONATAL SERVICES	B	-10,170		NEONATAL INTENSIVE CARE UNIT	31.01	0 33.26
33.27 OTHER REVENUE - GROUND TRANSPORT	B	-115,881		EMERGENCY	91.00	0 33.27
33.28 PACE CONSULTING AMORTIZATION	A			NEW CAP REL COSTS-BLDG & FIXT	1.00	10 33.28
33.30 OTHER REVENUE - DRIVER'S EDUC CON	B	-28,948		OCCUPATIONAL THERAPY	67.00	0 33.30
33.33 OTHER REVENUE - RAD ADMIN	B	-543		RADIOLOGY-DIAGNOSTIC	54.00	0 33.33
33.35 NONALLOWABLE CAPITALIZED INTERE	A	-13,123		NEW CAP REL COSTS-BLDG & FIXT	1.00	10 33.35
33.36 OTHER REVENUE - MAIN STREET PT	B			PHYSICAL THERAPY	66.00	0 33.36
33.39 PACE COMPONENT DEPREC 29 V 23 Y	A			NEW CAP REL COSTS-BLDG & FIXT	1.00	10 33.39
33.42 EXCESS CAPITALIZED INTEREST PAC	A	-9,762		NEW CAP REL COSTS-BLDG & FIXT	1.00	10 33.42
33.46 ALLOWABLE CAPITALIZED INTEREST	A	10,626		NEW CAP REL COSTS-BLDG & FIXT	1.00	10 33.46
33.48 NONALLOWABLE CAPITALIZED INTERE	A	-3,092		NEW CAP REL COSTS-BLDG & FIXT	1.00	10 33.48
33.50 INCORRECT LIFING ON ASBESTOS AN	A			NEW CAP REL COSTS-BLDG & FIXT	1.00	10 33.50
33.55 OTHER REVENUE - RENT	B	-223,593		NEW CAP REL COSTS-BLDG & FIXT	1.00	14 33.55
33.57 MEMBERSHIP REVENUE	B	-37,713		ADMINISTRATIVE & GENERAL	5.00	0 33.57
33.58 SPECIAL PROGRAM REVENUE	B	-4,598		ADMINISTRATIVE & GENERAL	5.00	0 33.58
33.59 SEMINAR REVENUE	B	-29,403		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.59
33.63 STERILIZATION REVENUE	B	-6,551		DELIVERY ROOM & LABOR ROOM	52.00	0 33.63
33.66 OTHER REVENUE - NUTRITIONAL SER	B	-33,578		DIETARY	10.00	0 33.66
33.76 OTHER REVENUE - CATH LAB	B	0		CARDIAC CATHETERIZATION	59.00	0 33.76
33.88 OTHER REVENUE - SBCSC PT	B	-236,561		PHYSICAL THERAPY	66.00	0 33.88
33.94 EDUC SERVICES EMS	B	-3,356		PARAMED ED PRGM-(SPECIFY)	23.00	0 33.94
33.96 PARKING GARAGE - OPERATING	A	-51,796		ADMINISTRATIVE & GENERAL	5.00	0 33.96
33.97 PARKING GARAGE - CAPITAL	A	-29,345		NEW CAP REL COSTS-BLDG & FIXT	1.00	10 33.97



ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0058

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From 01/01/2018  
To 12/31/2018

Worksheet A-8

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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
34.03 NON ALLOWABLE 1999 INTEREST	A	-905,045	NEW CAP REL COSTS-MVBLE EQUIP		2.00	11 34.03
34.23 ADMISSION REVENUE	B	-28,964	ADMINISTRATIVE & GENERAL		5.00	0 34.23
34.31 SKYWAY INTEREST AMORTIZATION	A	3,580	NEW CAP REL COSTS-BLDG & FIXT		1.00	10 34.31
34.36 OLD CAPITAL - BUILDING	A	26,887	NEW CAP REL COSTS-BLDG & FIXT		1.00	14 34.36
34.37 NEW CAPITAL BUILDING	A	-5,543	NEW CAP REL COSTS-BLDG & FIXT		1.00	14 34.37
35.02 OTHER REVENUE - AMBULANCE SUPPL	B	-113,115	CENTRAL SERVICES & SUPPLY		14.00	0 35.02
36.01 LOBBY EXPENSE	A	-12,922	ADMINISTRATIVE & GENERAL		5.00	0 36.01
36.05 HAF EXPENSE	A	-20,989,625	ADMINISTRATIVE & GENERAL		5.00	0 36.05
36.18 TRUSTEE FEES	A	-16,984	ADMINISTRATIVE & GENERAL		5.00	0 36.18
36.23 CONTRIBUTIONS	A	-362,634	ADMINISTRATIVE & GENERAL		5.00	0 36.23
36.25 NON-ALLOWED EXPENSES	A	-706	ADMINISTRATIVE & GENERAL		5.00	0 36.25
36.26 ENTRY FEES	B	-266,278	ADMINISTRATIVE & GENERAL		5.00	0 36.26
37.00 OTHER REVENUE - MATERNAL CHILD ADMIN	B	-9,500	ADULTS & PEDIATRICS		30.00	0 37.00
37.01 OTHER REVENUE - OSTC	B	-13,223	NURSING ADMINISTRATION		13.00	0 37.01
37.03 OTHER REV - TRAUMA SVCS	B	-18,600	EMERGENCY		91.00	0 37.03
39.00 OTHER REVENUE - TEAM PHARMACY	B	-253,594	DRUGS CHARGED TO PATIENTS		73.00	0 39.00
40.00 OTHER REVENUE - PEDS REHAB OT	B	-78,210	OCCUPATIONAL THERAPY		67.00	0 40.00
41.00 OTHER REVENUE - FCMC	B	-2,443	ADULTS & PEDIATRICS		30.00	0 41.00
42.00 OTHER REVENUE - PULMONARY MED/SURG	B	-1,426	ADULTS & PEDIATRICS		30.00	0 42.00
44.00 OTHER REVENUE - CARDIAC REHAB	B		CARDIOLOGY		76.00	0 44.00
44.01 OTHER REVENUE - OSTC	B		PHYSICAL THERAPY EAST BANK		66.01	0 44.01
44.02 OTHER REVENUE - SAFETY	B		NURSING ADMINISTRATION		13.00	0 44.02
44.03 OTHER REVENUE - 11 SOUTH	B		ADULTS & PEDIATRICS		30.00	0 44.03
44.04 OTHER REVENUE - 12 SOUTH	B		ADULTS & PEDIATRICS		30.00	0 44.04
44.05 OTHER REVENUE - SOCIAL SERVICES	B		SOCIAL SERVICE		17.00	0 44.05
44.06 OTHER REVENUE - PHARMACY	B	-53,668	DRUGS CHARGED TO PATIENTS		73.00	0 44.06
44.07 OTHER REVENUE - FPC	B	-11,880	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00	0 44.07
44.08 OTHER REVENUE - ICU	B		INTENSIVE CARE UNIT		31.00	0 44.08
44.09 OTHER REVENUE - INDIGENT CARE	B		SOCIAL SERVICE		17.00	0 44.09
44.10 OTHER REVENUE - ORNISH CARDIAC REHAB	B		CARDIOLOGY		76.00	0 44.10
44.11 OTHER REVENUE - RES SVCS	B		NURSING ADMINISTRATION		13.00	0 44.11
44.12 OTHER REVENUE - 8 SOUTH	B		ADULTS & PEDIATRICS		30.00	0 44.12
44.13 OTHER REVENUE - SOCIAL SVCS	B		SOCIAL SERVICE		17.00	0 44.13
44.14 BREMEN SALARIES TO HOME OFFICE	A		0		0.00	0 44.14
44.15 OTHER REVENUE - NSG FLOATS	B	-665	NURSING ADMINISTRATION		13.00	0 44.15
44.16 OTHER REVENUE - ER	B	-50	EMERGENCY		91.00	0 44.16
44.17 OTHER REVENUE - EPWORTH ADULT ACUTE	B	-296	ADULTS & PEDIATRICS		30.00	0 44.17
44.18 OTHER REVENUE - ENVIRONMENTAL PSYCH	B	-705	HOUSEKEEPING		9.00	0 44.18
44.19 OTHER REVENUE - HEART VASCULAR	B	-4,800	CARDIOLOGY		76.00	0 44.19
44.20 OTHER REVENUE - GIFT SHOP	B	-45,269	ADMINISTRATIVE & GENERAL		5.00	0 44.20
44.21 OTHER REVENUE - GROUNDS	B	-1,230	OPERATION OF PLANT		7.00	0 44.21
44.22 HOME OFFICE ADJUSTMENT	A	-257,598	NEW CAP REL COSTS-BLDG & FIXT		1.00	9 44.22
44.23 HOME OFFICE TO BUILDING	B	-598,684	NEW CAP REL COSTS-BLDG & FIXT		1.00	14 44.23
44.24 HOME OFFICE TO MME	B	-1,672,569	NEW CAP REL COSTS-MVBLE EQUIP		2.00	14 44.24
44.25 HOME OFFICE TO MAINTENANCE	B	-156,244	MAINTENANCE & REPAIRS		6.00	0 44.25
44.26 HOME OFFICE TO PLANT	B	-538,299	OPERATION OF PLANT		7.00	14 44.26
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-21,451,477				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-0058

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

Worksheet A-8-1

Date/Time Prepared: 5/29/2019 8:36 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00	HOME OFFICE OLD CAP-BUILD	0	0	1.00
2.00	0.00	HOME OFFICE OLD CAP-EQUIP	0	0	2.00
3.00	1.00	NEW CAP REL COSTS-BLDG & FIX	1,560,278	0	3.00
4.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	2,400,591	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	39,127,964	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	0	35,013,650	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		43,088,833	35,013,650	5.00

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

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

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

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

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

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

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

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

Provider CCN: 15-0058

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

Worksheet A-8-1

Date/Time Prepared:  
5/29/2019 8:36 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	0	0		1.00
2.00	0	0		2.00
3.00	1,560,278	10		3.00
4.00	2,400,591	10		4.00
4.01	39,127,964	0		4.01
4.02	-35,013,650	0		4.02
5.00	8,075,183			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

**B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:**

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0058

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

Worksheet A-8-2

Date/Time Prepared:  
5/29/2019 8:36 am

	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	4.00	DR. S	6,000	0	6,000	211,500	1	1.00
2.00	5.00	DR. AN	185,850	0	185,850	181,300	1,062	2.00
3.00	5.00	DR. Z	16,938	0	16,938	211,500	263	3.00
4.00	13.00	DR. H	2,100	0	2,100	211,500	34	4.00
5.00	13.00	DR. D	48,750	0	48,750	211,500	311	5.00
6.00	22.00	DR. H	170	0	170	211,500	1	6.00
7.00	30.00	DR. DU	12,188	0	12,188	211,500	1	7.00
8.00	31.00	DR. DE	53,769	0	53,769	211,500	1	8.00
9.00	30.00	DR. DT	8,880	0	8,880	211,500	1	9.00
10.00	31.00	DR. AW	32,850	0	32,850	211,500	1	10.00
11.00	31.00	DR. K	161,788	0	161,788	211,500	921	11.00
12.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	1,171,800	1,171,800	0	0	0	12.00
13.00	31.01	DR. L	67,083	67,083	0	0	0	13.00
14.00	31.01	AGGREGATE-NEONATAL INTENSIVE CARE UN	14,925	0	14,925	169,700	100	14.00
15.00	50.00	DR. C	34,344	0	34,344	246,400	224	15.00
16.00	50.00	AGGREGATE-OPERATING ROOM	3,296,169	3,296,169	0	0	0	16.00
17.00	50.00	DR. S	13,345	0	13,345	246,400	79	17.00
18.00	50.00	DR. H	27,300	0	27,300	246,400	182	18.00
19.00	50.00	DR. S	680	0	680	246,400	4	19.00
20.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	1,344,100	1,344,100	0	0	0	20.00
21.00	52.00	DR. DU	30,450	0	30,450	237,100	1	21.00
22.00	54.00	DR. D	700	0	700	260,300	1	22.00
23.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	47,818	0	47,818	271,900	239	23.00
24.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	301,000	301,000	0	0	0	24.00
25.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	4,700	0	4,700	271,900	24	25.00
26.00	54.00	DR. R	21,000	0	21,000	211,500	1	26.00
27.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	6,550	6,550	0	0	0	27.00
28.00	59.00	DR. A	15,400	0	15,400	211,500	1	28.00
29.00	59.00	DR. M	2,300	0	2,300	211,500	12	29.00
30.00	60.00	AGGREGATE-LABORATORY	23,110	0	23,110	260,300	154	30.00
31.00	66.00	DR. P	28,100	0	28,100	211,500	141	31.00
32.00	66.00	DR. CO	9,063	0	9,063	211,500	73	32.00
33.00	76.00	DR. F	1,000	0	1,000	211,500	1	33.00
34.00	76.00	AGGREGATE-CARDIOLOGY	3,580	3,580	0	0	0	34.00
35.00	76.00	AGGREGATE-CARDIOLOGY	108,792	108,792	0	0	0	35.00
36.00	76.00	DR. F	1,300	0	1,300	211,500	1	36.00
37.00	76.00	DR. S	1,200	0	1,200	211,500	1	37.00
38.00	76.00	DR. M	21,800	0	21,800	211,500	1	38.00
39.00	76.00	DR. D	550	0	550	211,500	1	39.00
40.00	76.00	DR. L	38,500	0	38,500	211,500	1	40.00
41.00	90.30	DR. M	3,600	0	3,600	211,500	1	41.00
42.00	90.50	DR. F	50,400	0	50,400	211,500	401	42.00
43.00	90.50	DR. AN	28,725	0	28,725	211,500	192	43.00
44.00	91.00	DR. BO	100,000	0	100,000	211,500	133	44.00
45.00	91.00	AGGREGATE-EMERGENCY	8,280,670	8,280,670	0	0	0	45.00
46.00	91.00	AGGREGATE-EMERGENCY	1,360	0	1,360	211,500	8	46.00
47.00	91.00	DR. R	45,543	0	45,543	211,500	237	47.00
48.00	91.00	DR. R	53,380	0	53,380	211,500	314	48.00
49.00	91.00	DR. S	235,960	0	235,960	211,500	1,388	49.00
50.00	91.00	DR. T	408,532	0	408,532	211,500	131	50.00
51.00	57.00	AGGREGATE-CT SCAN	29,325	29,325	0	0	0	51.00
200.00			16,403,437	14,609,069	1,794,368		6,644	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	4.00	DR. S	102	5	0	0	0	1.00
2.00	5.00	DR. AN	92,568	4,628	0	0	0	2.00
3.00	5.00	DR. Z	26,742	1,337	0	0	0	3.00
4.00	13.00	DR. H	3,457	173	0	0	0	4.00
5.00	13.00	DR. D	31,623	1,581	0	0	0	5.00
6.00	22.00	DR. H	102	5	0	0	0	6.00
7.00	30.00	DR. DU	102	5	0	0	0	7.00
8.00	31.00	DR. DE	102	5	0	0	0	8.00
9.00	30.00	DR. DT	102	5	0	0	0	9.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0058

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

Worksheet A-8-2

Date/Time Prepared: 5/29/2019 8:36 am

	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	
10.00	31.00	DR. AW	102	5	0	0	0	10.00
11.00	31.00	DR. K	93,650	4,683	0	0	0	11.00
12.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	12.00
13.00	31.01	DR. L	0	0	0	0	0	13.00
14.00	31.01	AGGREGATE-NEONATAL INTENSIVE CARE UN	8,159	408	0	0	0	14.00
15.00	50.00	DR. C	26,535	1,327	0	0	0	15.00
16.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	16.00
17.00	50.00	DR. S	9,359	468	0	0	0	17.00
18.00	50.00	DR. H	21,560	1,078	0	0	0	18.00
19.00	50.00	DR. S	474	24	0	0	0	19.00
20.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	20.00
21.00	52.00	DR. DU	114	6	0	0	0	21.00
22.00	54.00	DR. D	125	6	0	0	0	22.00
23.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	31,242	1,562	0	0	0	23.00
24.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	24.00
25.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	3,137	157	0	0	0	25.00
26.00	54.00	DR. R	102	5	0	0	0	26.00
27.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	27.00
28.00	59.00	DR. A	102	5	0	0	0	28.00
29.00	59.00	DR. M	1,220	61	0	0	0	29.00
30.00	60.00	AGGREGATE-LABORATORY	19,272	964	0	0	0	30.00
31.00	66.00	DR. P	14,337	717	0	0	0	31.00
32.00	66.00	DR. CO	7,423	371	0	0	0	32.00
33.00	76.00	DR. F	102	5	0	0	0	33.00
34.00	76.00	AGGREGATE-CARDIOLOGY	0	0	0	0	0	34.00
35.00	76.00	AGGREGATE-CARDIOLOGY	0	0	0	0	0	35.00
36.00	76.00	DR. F	102	5	0	0	0	36.00
37.00	76.00	DR. S	102	5	0	0	0	37.00
38.00	76.00	DR. M	102	5	0	0	0	38.00
39.00	76.00	DR. D	102	5	0	0	0	39.00
40.00	76.00	DR. L	102	5	0	0	0	40.00
41.00	90.30	DR. M	102	5	0	0	0	41.00
42.00	90.50	DR. F	40,775	2,039	0	0	0	42.00
43.00	90.50	DR. AN	19,523	976	0	0	0	43.00
44.00	91.00	DR. BO	13,524	676	0	0	0	44.00
45.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	45.00
46.00	91.00	AGGREGATE-EMERGENCY	813	41	0	0	0	46.00
47.00	91.00	DR. R	24,099	1,205	0	0	0	47.00
48.00	91.00	DR. R	31,928	1,596	0	0	0	48.00
49.00	91.00	DR. S	141,136	7,057	0	0	0	49.00
50.00	91.00	DR. T	13,320	666	0	0	0	50.00
51.00	57.00	AGGREGATE-CT SCAN	0	0	0	0	0	51.00
200.00			677,645	33,882	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	4.00	DR. S	0	102	5,898	5,898	1.00
2.00	5.00	DR. AN	0	92,568	93,282	93,282	2.00
3.00	5.00	DR. Z	0	26,742	0	0	3.00
4.00	13.00	DR. H	0	3,457	0	0	4.00
5.00	13.00	DR. D	0	31,623	17,127	17,127	5.00
6.00	22.00	DR. H	0	102	68	68	6.00
7.00	30.00	DR. DU	0	102	12,086	12,086	7.00
8.00	31.00	DR. DE	0	102	53,667	53,667	8.00
9.00	30.00	DR. DT	0	102	8,778	8,778	9.00
10.00	31.00	DR. AW	0	102	32,748	32,748	10.00
11.00	31.00	DR. K	0	93,650	68,138	68,138	11.00
12.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	1,171,800	12.00
13.00	31.01	DR. L	0	0	0	67,083	13.00
14.00	31.01	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	8,159	6,766	6,766	14.00
15.00	50.00	DR. C	0	26,535	7,809	7,809	15.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0058

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

Worksheet A-8-2

Date/Time Prepared:  
5/29/2019 8:36 am

	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		
16.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	3,296,169		16.00
17.00	50.00	DR. S	0	9,359	3,986	3,986		17.00
18.00	50.00	DR. H	0	21,560	5,740	5,740		18.00
19.00	50.00	DR. S	0	474	206	206		19.00
20.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	1,344,100		20.00
21.00	52.00	DR. DU	0	114	30,336	30,336		21.00
22.00	54.00	DR. D	0	125	575	575		22.00
23.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	31,242	16,576	16,576		23.00
24.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	301,000		24.00
25.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	3,137	1,563	1,563		25.00
26.00	54.00	DR. R	0	102	20,898	20,898		26.00
27.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	6,550		27.00
28.00	59.00	DR. A	0	102	15,298	15,298		28.00
29.00	59.00	DR. M	0	1,220	1,080	1,080		29.00
30.00	60.00	AGGREGATE-LABORATORY	0	19,272	3,838	3,838		30.00
31.00	66.00	DR. P	0	14,337	13,763	13,763		31.00
32.00	66.00	DR. CO	0	7,423	1,640	1,640		32.00
33.00	76.00	DR. F	0	102	898	898		33.00
34.00	76.00	AGGREGATE-CARDIOLOGY	0	0	0	3,580		34.00
35.00	76.00	AGGREGATE-CARDIOLOGY	0	0	0	108,792		35.00
36.00	76.00	DR. F	0	102	1,198	1,198		36.00
37.00	76.00	DR. S	0	102	1,098	1,098		37.00
38.00	76.00	DR. M	0	102	21,698	21,698		38.00
39.00	76.00	DR. D	0	102	448	448		39.00
40.00	76.00	DR. L	0	102	38,398	38,398		40.00
41.00	90.30	DR. M	0	102	3,498	3,498		41.00
42.00	90.50	DR. F	0	40,775	9,625	9,625		42.00
43.00	90.50	DR. AN	0	19,523	9,202	9,202		43.00
44.00	91.00	DR. BO	0	13,524	86,476	86,476		44.00
45.00	91.00	AGGREGATE-EMERGENCY	0	0	0	8,280,670		45.00
46.00	91.00	AGGREGATE-EMERGENCY	0	813	547	547		46.00
47.00	91.00	DR. R	0	24,099	21,444	21,444		47.00
48.00	91.00	DR. R	0	31,928	21,452	21,452		48.00
49.00	91.00	DR. S	0	141,136	94,824	94,824		49.00
50.00	91.00	DR. T	0	13,320	395,212	395,212		50.00
51.00	57.00	AGGREGATE-CT SCAN	0	0	0	29,325		51.00
200.00			0	677,645	1,127,884	15,736,953		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	22,197,039	22,197,039			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	15,681,855		15,681,855		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	20,211,755	3,951	2,791	20,218,497	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	55,569,100	401,772	283,846	772,569	5.00
6.00 00600	MAINTENANCE & REPAIRS	4,542,203	53,539	37,824	76,432	6.00
7.00 00700	OPERATION OF PLANT	9,556,425	3,591,803	2,537,551	372,916	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,583,352	2,675	1,890	0	8.00
9.00 00900	HOUSEKEEPING	5,156,923	386,076	272,756	417,163	9.00
10.00 01000	DIETARY	3,613,385	484,260	342,122	273,588	10.00
11.00 01100	CAFETERIA	859,045	82,222	58,088	185,976	11.00
13.00 01300	NURSING ADMINISTRATION	3,057,248	205,227	144,989	304,717	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	9,575,327	570,379	402,964	295,249	14.00
15.00 01500	PHARMACY	6,552,299	205,599	145,252	36,991	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	86,048	60,792	0	16.00
17.00 01700	SOCIAL SERVICE	3,986,200	149,579	105,676	412,450	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,938,385	0	0	266,576	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	5,267,244	283,179	200,061	451,523	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	138,709	65,923	46,573	12,537	23.00
23.01 02301	PARAMED ED	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	50,117,156	4,299,059	3,037,217	4,675,579	30.00
31.00 03100	INTENSIVE CARE UNIT	9,990,998	546,320	385,967	904,628	31.00
31.01 02060	NEONATAL INTENSIVE CARE UNIT	7,594,155	517,761	365,790	826,492	31.01
40.00 04000	SUBPROVIDER - I PF	1,467,563	224,697	158,745	150,271	40.00
41.00 04100	SUBPROVIDER - I RF	1,606,331	207,937	146,904	161,042	41.00
43.00 04300	NURSERY	1,732,112	80,875	57,137	187,283	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	29,511,413	1,890,587	1,335,669	1,941,304	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	6,329,218	649,465	458,837	561,370	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	14,152,993	1,038,428	733,633	1,213,732	54.00
57.00 05700	CT SCAN	1,838,237	50,492	35,672	161,248	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,078,626	76,446	54,008	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,773,514	270,299	190,962	162,937	59.00
60.00 06000	LABORATORY	11,545,862	195,553	138,155	349,237	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	5,809,976	130,676	92,321	462,289	65.00
66.00 06600	PHYSICAL THERAPY	3,513,669	230,348	162,738	371,892	66.00
66.01 06602	PHYSICAL THERAPY EAST BANK	1,287,081	0	0	138,347	66.01
66.10 06601	PHYSICAL THERAPY LIVING CENTER	509,570	0	0	57,068	66.10
67.00 06700	OCCUPATIONAL THERAPY	2,154,290	114,519	80,906	244,585	67.00
67.10 06701	OCCUPATIONAL THERAPY LIVING CENTER	325,766	0	0	34,742	67.10
68.00 06800	SPEECH PATHOLOGY	1,216,954	6,998	4,944	135,713	68.00
68.10 06801	SPEECH THERAPY LIVING CENTER	228,994	0	0	25,080	68.10
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,311,293	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	26,351,594	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	32,876,713	0	0	864,104	73.00
76.00 03020	CARDIOLOGY	3,736,849	60,129	42,480	359,662	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.10 09001	FAMILY PRACTICE CLINIC	0	0	0	0	90.10
90.30 09002	HEMATOLOGY ONCOLOGY CLINIC	1,000,869	179,148	126,565	103,844	90.30
90.50 09004	SLEEP DISORDERS CLINIC	822,420	56,462	39,890	82,437	90.50
91.00 09100	EMERGENCY	19,780,293	622,093	439,499	1,525,214	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	418,151,003	18,020,524	12,731,214	19,578,787	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	84,348	59,590	0	190.00
193.00 19300	NONPAID WORKERS	683,731	3,980,518	2,812,173	41,520	193.00
193.10 19301	HEALTH PROPERTIES	3,965,481	0	0	305,540	193.10
193.40 19303	LEIGHTON CENTER	0	111,649	78,878	0	193.40
193.50 19305	WELLNESS CENTER	3,061,223	0	0	258,206	193.50
193.80 19308	UNUSED SPACE	0	0	0	0	193.80
193.90 19309	OCCUPATIONAL HEALTH	0	0	0	0	193.90
193.91 19310	RESEARCH AND PROTOCOL	0	0	0	0	193.91
193.92 19311	CCOP	0	0	0	0	193.92

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

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

Worksheet B  
Part I  
Date/Time Prepared:  
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
193.93 19312 RESEARCH ADMIN	313,992	0	0	34,444	348,436	193.93
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)	426,175,430	22,197,039	15,681,855	20,218,497	426,175,430	202.00



COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	57,027,287				5.00
6.00	00600	MAINTENANCE & REPAIRS	727,615	5,437,613			6.00
7.00	00700	OPERATION OF PLANT	2,480,795	898,474	19,437,964		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	245,306	669	2,866	1,836,758	8.00
9.00	00900	HOUSEKEEPING	962,880	96,575	413,564	0	7,705,937
10.00	01000	DIETARY	728,133	121,136	518,739	0	182,499
11.00	01100	CAFETERIA	183,113	20,567	88,076	0	0
13.00	01300	NURSING ADMINISTRATION	573,469	51,337	219,839	0	10,228
14.00	01400	CENTRAL SERVICES & SUPPLY	1,675,201	142,678	610,990	77	226,472
15.00	01500	PHARMACY	1,072,134	51,430	220,237	0	23,678
16.00	01600	MEDICAL RECORDS & LIBRARY	22,684	21,525	92,175	0	46,148
17.00	01700	SOCIAL SERVICE	718,949	37,417	160,229	0	14,980
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	340,629	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	958,105	70,836	303,341	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	40,744	16,490	70,616	117,474	0
23.01	02301	PARAMED ED	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	9,598,053	1,075,390	4,605,153	600,011	3,376,468
31.00	03100	INTENSIVE CARE UNIT	1,827,211	136,660	585,218	96	145,532
31.01	02060	NEONATAL INTENSIVE CARE UNIT	1,437,340	129,516	554,626	9,661	368,299
40.00	04000	SUBPROVIDER - IPF	309,163	56,207	240,695	0	244,754
41.00	04100	SUBPROVIDER - IRF	327,846	52,015	222,742	55,316	268,030
43.00	04300	NURSERY	317,834	20,231	86,634	3,158	143,196
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	5,357,312	472,922	2,025,196	562,706	998,588
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,235,693	162,461	695,707	118,411	326,903
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,647,651	259,758	1,112,364	155	415,494
57.00	05700	CT SCAN	322,197	12,630	54,087	80,587	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	186,782	19,123	81,889	90	0
59.00	05900	CARDIAC CATHETERIZATION	370,406	67,614	289,544	0	146,579
60.00	06000	LABORATORY	1,889,143	48,917	209,477	0	89,155
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,003,408	32,688	139,980	0	14,577
66.00	06600	PHYSICAL THERAPY	660,978	57,621	246,749	0	62,981
66.01	06602	PHYSICAL THERAPY EAST BANK	220,204	0	0	0	0
66.10	06601	PHYSICAL THERAPY LIVING CENTER	87,536	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	400,775	28,646	122,672	0	16,832
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	55,692	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	210,809	1,751	7,496	0	2,658
68.10	06801	SPEECH THERAPY LIVING CENTER	39,250	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,592,919	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,070,873	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	5,212,383	0	0	0	0
76.00	03020	CARDIOLOGY	648,693	15,041	64,411	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	217,887	44,813	191,903	0	27,705
90.50	09004	SLEEP DISORDERS CLINIC	154,670	14,124	60,482	7	0
91.00	09100	EMERGENCY	3,455,337	155,614	666,386	289,009	290,339
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,587,802	4,392,876	14,964,083	1,836,758	7,442,095
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,236	21,099	90,353	0	0
193.00	19300	NONPAID WORKERS	1,161,394	995,710	4,263,930	0	263,842
193.10	19301	HEALTH PROPERTIES	659,800	0	0	0	0
193.40	19303	LEIGHTON CENTER	29,433	27,928	119,598	0	0
193.50	19305	WELLNESS CENTER	512,795	0	0	0	0
193.80	19308	UNUSED SPACE	0	0	0	0	0
193.90	19309	OCCUPATIONAL HEALTH	0	0	0	0	0
193.91	19310	RESEARCH AND PROTOCOL	0	0	0	0	0
193.92	19311	CCOP	0	0	0	0	0
193.93	19312	RESEARCH ADMIN	53,827	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	57,027,287	5,437,613	19,437,964	1,836,758	7,705,937

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

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

Worksheet B  
Part I  
Date/Time Prepared:  
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	6,263,862					10.00
11.00	01100	0	1,477,087				11.00
13.00	01300	0	35,500	4,602,554			13.00
14.00	01400	0	36,497	53	13,535,887		14.00
15.00	01500	0	55,657	0	0	8,363,277	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	35,914	10,937	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	38,597	0	0	0	22.00
23.00	02300	0	1,120	202	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	5,196,619	426,504	1,988,060	0	960	30.00
31.00	03100	644,704	74,092	470,007	0	0	31.00
31.01	02060	0	53,421	368,671	0	1,074	31.01
40.00	04000	213,791	16,127	54,949	0	0	40.00
41.00	04100	208,748	12,802	68,091	0	0	41.00
43.00	04300	0	13,921	76,325	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	145,607	610,413	0	124	50.00
52.00	05200	0	43,989	258,389	0	19	52.00
54.00	05400	0	94,505	119,610	0	703	54.00
57.00	05700	0	11,481	188	0	0	57.00
58.00	05800	0	0	0	0	203	58.00
59.00	05900	0	10,968	32,805	0	119	59.00
60.00	06000	0	41,579	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	38,025	278	0	1,194	65.00
66.00	06600	0	24,930	20,663	0	4	66.00
66.01	06602	0	11,046	0	0	0	66.01
66.10	06601	0	3,954	0	0	0	66.10
67.00	06700	0	18,546	0	0	0	67.00
67.10	06701	0	2,914	0	0	0	67.10
68.00	06800	0	9,065	0	0	7	68.00
68.10	06801	0	1,763	0	0	0	68.10
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	7,850,814	0	71.00
72.00	07200	0	0	0	5,685,073	0	72.00
73.00	07300	0	0	0	0	8,354,235	73.00
76.00	03020	0	19,224	33,368	0	390	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.10	09001	0	0	0	0	0	90.10
90.30	09002	0	7,872	38,756	0	0	90.30
90.50	09004	0	6,261	0	0	0	90.50
91.00	09100	0	104,659	434,927	0	3,647	91.00
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0	0	113.00
118.00		6,263,862	1,396,540	4,586,692	13,535,887	8,362,679	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
193.00	19300	0	3,725	7,522	0	598	193.00
193.10	19301	0	41,445	50	0	0	193.10
193.40	19303	0	0	0	0	0	193.40
193.50	19305	0	32,618	0	0	0	193.50
193.80	19308	0	0	0	0	0	193.80
193.90	19309	0	0	0	0	0	193.90
193.91	19310	0	0	0	0	0	193.91
193.92	19311	0	0	0	0	0	193.92
193.93	19312	0	2,759	8,290	0	0	193.93
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		6,263,862	1,477,087	4,602,554	13,535,887	8,363,277	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2019 8:36 am

Line	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM	
				SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
				16.00	17.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	329,372					16.00
17.00	01700 SOCIAL SERVICE	0	5,632,331				17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	2,545,590			21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	7,572,886		22.00
23.00	02300 PARAMED PRGM-(SPECIFY)	0	0	0	0	510,388	23.00
23.01	02301 PARAMED	0	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	53,916	3,996,808	1,652,384	4,915,686	0	30.00
31.00	03100 INTENSIVE CARE UNIT	4,124	185,596	7,498	22,306	0	31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT	1,443	103,387	0	0	0	31.01
40.00	04000 SUBPROVIDER - IPF	2,887	636,492	0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	1,340	101,566	0	0	0	41.00
43.00	04300 NURSERY	1,031	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	75,666	911	95,600	284,401	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	11,386	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	56,906	115,229	12,184	36,247	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	25,566	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	31,867	94,800	0	65.00
66.00	06600 PHYSICAL THERAPY	35,566	0	0	0	0	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0	0	0	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	8,763	0	0	0	0	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	4,021	0	0	0	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
76.00	03020 RADIOLOGY	23,814	0	54,361	161,718	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	522,052	1,553,055	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	105,665	3,749	11,153	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0	0	0	0	0	90.50
91.00	09100 EMERGENCY	34,329	375,291	136,840	407,084	510,388	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	329,372	5,632,331	2,516,535	7,486,450	510,388	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
193.00	19300 NONPAID WORKERS	0	0	29,055	86,436	0	193.00
193.10	19301 HEALTH PROPERTIES	0	0	0	0	0	193.10
193.40	19303 LEIGHTON CENTER	0	0	0	0	0	193.40
193.50	19305 WELLNESS CENTER	0	0	0	0	0	193.50
193.80	19308 UNUSED SPACE	0	0	0	0	0	193.80
193.90	19309 OCCUPATIONAL HEALTH	0	0	0	0	0	193.90
193.91	19310 RESEARCH AND PROTOCOL	0	0	0	0	0	193.91
193.92	19311 CCOP	0	0	0	0	0	193.92
193.93	19312 RESEARCH ADMIN	0	0	0	0	0	193.93
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			16.00	17.00		
201.00   Negative Cost Centers	0	0	0	0	0	201.00
202.00   TOTAL (sum lines 118 through 201)	329,372	5,632,331	2,545,590	7,572,886	510,388	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description		PARAMED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.01	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	PARAMED PRGM-(SPECIFY)				23.00
23.01	02301	PARAMED ED	0			23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	0	99,615,023	-6,568,070	93,046,953
31.00	03100	INTENSIVE CARE UNIT	0	15,930,957	-29,804	15,901,153
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	12,331,636	0	12,331,636
40.00	04000	SUBPROVIDER - IPF	0	3,776,341	0	3,776,341
41.00	04100	SUBPROVIDER - IRF	0	3,440,710	0	3,440,710
43.00	04300	NURSERY	0	2,719,737	0	2,719,737
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	45,308,419	-380,001	44,928,418
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,851,848	0	10,851,848
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,009,592	-48,431	21,961,161
57.00	05700	CT SCAN	0	2,566,819	0	2,566,819
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,497,167	0	1,497,167
59.00	05900	CARDIAC CATHETERIZATION	0	3,315,747	0	3,315,747
60.00	06000	LABORATORY	0	14,532,644	0	14,532,644
60.01	06001	BLOOD LABORATORY	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	7,852,079	-126,667	7,725,412
66.00	06600	PHYSICAL THERAPY	0	5,388,139	0	5,388,139
66.01	06602	PHYSICAL THERAPY EAST BANK	0	1,656,678	0	1,656,678
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	658,128	0	658,128
67.00	06700	OCCUPATIONAL THERAPY	0	3,190,534	0	3,190,534
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	419,114	0	419,114
68.00	06800	SPEECH PATHOLOGY	0	1,600,416	0	1,600,416
68.10	06801	SPEECH THERAPY LIVING CENTER	0	295,087	0	295,087
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,755,026	0	19,755,026
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	36,107,540	0	36,107,540
73.00	07300	DRUGS CHARGED TO PATIENTS	0	47,307,435	0	47,307,435
76.00	03020	CARDIOLOGY	0	5,220,140	-216,079	5,004,061
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0	0
90.10	09001	FAMILY PRACTICE CLINIC	0	2,075,107	-2,075,107	0
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	2,059,929	-14,902	2,045,027
90.50	09004	SLEEP DISORDERS CLINIC	0	1,236,753	0	1,236,753
91.00	09100	EMERGENCY	0	29,230,949	-543,924	28,687,025
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	401,949,694	-10,002,985	391,946,709
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	277,626	0	277,626
193.00	19300	NONPAID WORKERS	0	14,330,154	-115,491	14,214,663
193.10	19301	HEALTH PROPERTIES	0	4,972,316	0	4,972,316
193.40	19303	LEIGHTON CENTER	0	367,486	0	367,486
193.50	19305	WELLNESS CENTER	0	3,864,842	0	3,864,842
193.80	19308	UNUSED SPACE	0	0	0	0
193.90	19309	OCCUPATIONAL HEALTH	0	0	0	0
193.91	19310	RESEARCH AND PROTOCOL	0	0	0	0
193.92	19311	CCOP	0	0	0	0
193.93	19312	RESEARCH ADMIN	0	413,312	0	413,312
200.00		Cross Foot Adjustments	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description		PARAMED ED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.01	24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	426,175,430	-10,118,476	416,056,954		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0058

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,951	2,791	6,742	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	401,772	283,846	685,618	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	53,539	37,824	91,363	6.00
7.00 00700	OPERATION OF PLANT	0	3,591,803	2,537,551	6,129,354	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	2,675	1,890	4,565	8.00
9.00 00900	HOUSEKEEPING	0	386,076	272,756	658,832	9.00
10.00 01000	DIETARY	0	484,260	342,122	826,382	10.00
11.00 01100	CAFETERIA	0	82,222	58,088	140,310	11.00
13.00 01300	NURSING ADMINISTRATION	0	205,227	144,989	350,216	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	570,379	402,964	973,343	14.00
15.00 01500	PHARMACY	0	205,599	145,252	350,851	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	86,048	60,792	146,840	16.00
17.00 01700	SOCIAL SERVICE	0	149,579	105,676	255,255	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	283,179	200,061	483,240	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	65,923	46,573	112,496	23.00
23.01 02301	PARAMED ED	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	4,299,059	3,037,217	7,336,276	30.00
31.00 03100	INTENSIVE CARE UNIT	0	546,320	385,967	932,287	31.00
31.01 02060	NEONATAL INTENSIVE CARE UNIT	0	517,761	365,790	883,551	31.01
40.00 04000	SUBPROVIDER - IPF	0	224,697	158,745	383,442	40.00
41.00 04100	SUBPROVIDER - IRF	0	207,937	146,904	354,841	41.00
43.00 04300	NURSERY	0	80,875	57,137	138,012	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	1,890,587	1,335,669	3,226,256	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	649,465	458,837	1,108,302	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	1,038,428	733,633	1,772,061	54.00
57.00 05700	CT SCAN	0	50,492	35,672	86,164	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	76,446	54,008	130,454	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	270,299	190,962	461,261	59.00
60.00 06000	LABORATORY	0	195,553	138,155	333,708	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	130,676	92,321	222,997	65.00
66.00 06600	PHYSICAL THERAPY	0	230,348	162,738	393,086	66.00
66.01 06602	PHYSICAL THERAPY EAST BANK	0	0	0	0	66.01
66.10 06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	0	66.10
67.00 06700	OCCUPATIONAL THERAPY	0	114,519	80,906	195,425	67.00
67.10 06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	67.10
68.00 06800	SPEECH PATHOLOGY	0	6,998	4,944	11,942	68.00
68.10 06801	SPEECH THERAPY LIVING CENTER	0	0	0	0	68.10
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
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	0	73.00
76.00 03020	CARDIOLOGY	0	60,129	42,480	102,609	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.10 09001	FAMILY PRACTICE CLINIC	0	0	0	0	90.10
90.30 09002	HEMATOLOGY ONCOLOGY CLINIC	0	179,148	126,565	305,713	90.30
90.50 09004	SLEEP DISORDERS CLINIC	0	56,462	39,890	96,352	90.50
91.00 09100	EMERGENCY	0	622,093	439,499	1,061,592	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	18,020,524	12,731,214	30,751,738	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	84,348	59,590	143,938	190.00
193.00 19300	NONPAID WORKERS	0	3,980,518	2,812,173	6,792,691	193.00
193.10 19301	HEALTH PROPERTIES	0	0	0	0	193.10
193.40 19303	LEIGHTON CENTER	0	111,649	78,878	190,527	193.40
193.50 19305	WELLNESS CENTER	0	0	0	0	193.50
193.80 19308	UNUSED SPACE	0	0	0	0	193.80
193.90 19309	OCCUPATIONAL HEALTH	0	0	0	0	193.90
193.91 19310	RESEARCH AND PROTOCOL	0	0	0	0	193.91
193.92 19311	CCOP	0	0	0	0	193.92
193.93 19312	RESEARCH ADMIN	0	0	0	0	193.93

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0058

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
	0			2A	4.00	
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	22,197,039	15,681,855	37,878,894	6,742	202.00



ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0058

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	685,876					5.00
6.00	00600	8,751	100,140				6.00
7.00	00700	29,837	16,547	6,175,863			7.00
8.00	00800	2,950	12	910	8,437		8.00
9.00	00900	11,581	1,779	131,398	0	803,730	9.00
10.00	01000	8,757	2,231	164,815	0	19,035	10.00
11.00	01100	2,202	379	27,984	0	0	11.00
13.00	01300	6,897	945	69,848	0	1,067	13.00
14.00	01400	20,148	2,628	194,125	0	23,621	14.00
15.00	01500	12,895	947	69,974	0	2,470	15.00
16.00	01600	273	396	29,286	0	4,813	16.00
17.00	01700	8,647	689	50,908	0	1,562	17.00
21.00	02100	4,097	0	0	0	0	21.00
22.00	02200	11,523	1,305	96,378	0	0	22.00
23.00	02300	490	304	22,436	540	0	23.00
23.01	02301	0	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	115,439	19,803	1,463,155	2,756	352,165	30.00
31.00	03100	21,976	2,517	185,937	0	15,179	31.00
31.01	02060	17,287	2,385	176,217	44	38,414	31.01
40.00	04000	3,718	1,035	76,474	0	25,528	40.00
41.00	04100	3,943	958	70,770	254	27,956	41.00
43.00	04300	3,823	373	27,525	15	14,935	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	64,434	8,709	643,449	2,585	104,153	50.00
52.00	05200	14,862	2,992	221,041	544	34,096	52.00
54.00	05400	31,844	4,784	353,422	1	43,336	54.00
57.00	05700	3,875	233	17,185	370	0	57.00
58.00	05800	2,246	352	26,018	0	0	58.00
59.00	05900	4,455	1,245	91,994	0	15,288	59.00
60.00	06000	22,721	901	66,555	0	9,299	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	12,068	602	44,475	0	1,520	65.00
66.00	06600	7,950	1,061	78,398	0	6,569	66.00
66.01	06602	2,648	0	0	0	0	66.01
66.10	06601	1,053	0	0	0	0	66.10
67.00	06700	4,820	528	38,976	0	1,756	67.00
67.10	06701	670	0	0	0	0	67.10
68.00	06800	2,535	32	2,382	0	277	68.00
68.10	06801	472	0	0	0	0	68.10
70.00	07000	0	0	0	0	0	70.00
71.00	07100	19,158	0	0	0	0	71.00
72.00	07200	48,961	0	0	0	0	72.00
73.00	07300	62,690	0	0	0	0	73.00
76.00	03020	7,802	277	20,465	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.10	09001	0	0	0	0	0	90.10
90.30	09002	2,621	825	60,972	0	2,890	90.30
90.50	09004	1,860	260	19,217	0	0	90.50
91.00	09100	41,558	2,866	211,725	1,328	30,282	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		656,537	80,900	4,754,414	8,437	776,211	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	267	389	28,707	0	0	190.00
193.00	19300	13,968	18,337	1,354,743	0	27,519	193.00
193.10	19301	7,936	0	0	0	0	193.10
193.40	19303	354	514	37,999	0	0	193.40
193.50	19305	6,167	0	0	0	0	193.50
193.80	19308	0	0	0	0	0	193.80
193.90	19309	0	0	0	0	0	193.90
193.91	19310	0	0	0	0	0	193.91
193.92	19311	0	0	0	0	0	193.92
193.93	19312	647	0	0	0	0	193.93
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		685,876	100,140	6,175,863	8,437	803,730	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0058		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part II Date/Time Prepared: 5/29/2019 8:36 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,021,312					10.00
11.00	01100	CAFETERIA	0	170,937				11.00
13.00	01300	NURSING ADMINISTRATION	0	4,108	433,183			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,224	5	1,218,193		14.00
15.00	01500	PHARMACY	0	6,441	0	0	443,590	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,156	1,029	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	4,467	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	130	19	0	0	23.00
23.01	02301	PARAMED ED	0	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	847,300	49,357	187,110	0	51	30.00
31.00	03100	INTENSIVE CARE UNIT	105,118	8,574	44,236	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	6,182	34,699	0	57	31.01
40.00	04000	SUBPROVIDER - I PF	34,858	1,866	5,172	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	34,036	1,482	6,409	0	0	41.00
43.00	04300	NURSERY	0	1,611	7,184	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	16,850	57,451	0	7	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,091	24,319	0	1	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,937	11,257	0	37	54.00
57.00	05700	CT SCAN	0	1,329	18	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	11	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,269	3,088	0	6	59.00
60.00	06000	LABORATORY	0	4,812	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	4,400	26	0	63	65.00
66.00	06600	PHYSICAL THERAPY	0	2,885	1,945	0	0	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	1,278	0	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	458	0	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	2,146	0	0	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	337	0	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	0	1,049	0	0	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	204	0	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	706,552	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	511,641	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	443,111	73.00
76.00	03020	CARDIOLOGY	0	2,225	3,141	0	21	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	911	3,648	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	725	0	0	0	90.50
91.00	09100	EMERGENCY	0	12,112	40,934	0	193	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,021,312	161,616	431,690	1,218,193	443,558	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
193.00	19300	NONPAID WORKERS	0	431	708	0	32	193.00
193.10	19301	HEALTH PROPERTIES	0	4,796	5	0	0	193.10
193.40	19303	LEIGHTON CENTER	0	0	0	0	0	193.40
193.50	19305	WELLNESS CENTER	0	3,775	0	0	0	193.50
193.80	19308	UNUSED SPACE	0	0	0	0	0	193.80
193.90	19309	OCCUPATIONAL HEALTH	0	0	0	0	0	193.90
193.91	19310	RESEARCH AND PROTOCOL	0	0	0	0	0	193.91
193.92	19311	CCOP	0	0	0	0	0	193.92
193.93	19312	RESEARCH ADMIN	0	319	780	0	0	193.93
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,021,312	170,937	433,183	1,218,193	443,590	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			16.00	17.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	181,608				16.00
17.00 01700	SOCIAL SERVICE	0	322,384			17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	4,186		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	597,064	22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00
23.01 02301	PARAMED PRGM	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	29,728	228,770			30.00
31.00 03100	INTENSIVE CARE UNIT	2,274	10,623			31.00
31.01 02060	NEONATAL INTENSIVE CARE UNIT	796	5,918			31.01
40.00 04000	SUBPROVIDER - IPF	1,592	36,432			40.00
41.00 04100	SUBPROVIDER - IRF	739	5,813			41.00
43.00 04300	NURSERY	568	0			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	41,721	52			50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	652			52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	31,376	6,595			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	14,097	0			60.00
60.01 06001	BLOOD LABORATORY	0	0			60.01
65.00 06500	RESPIRATORY THERAPY	0	0			65.00
66.00 06600	PHYSICAL THERAPY	19,610	0			66.00
66.01 06602	PHYSICAL THERAPY EAST BANK	0	0			66.01
66.10 06601	PHYSICAL THERAPY LIVING CENTER	0	0			66.10
67.00 06700	OCCUPATIONAL THERAPY	4,832	0			67.00
67.10 06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0			67.10
68.00 06800	SPEECH PATHOLOGY	2,217	0			68.00
68.10 06801	SPEECH THERAPY LIVING CENTER	0	0			68.10
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0			70.00
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	0			73.00
76.00 03020	CARDIOLOGY	13,130	0			76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0			90.00
90.10 09001	FAMILY PRACTICE CLINIC	0	0			90.10
90.30 09002	HEMATOLOGY ONCOLOGY CLINIC	0	6,048			90.30
90.50 09004	SLEEP DISORDERS CLINIC	0	0			90.50
91.00 09100	EMERGENCY	18,928	21,481			91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE	0	0			113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	181,608	322,384	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
193.00 19300	NONPAID WORKERS	0	0			193.00
193.10 19301	HEALTH PROPERTIES	0	0			193.10
193.40 19303	LEIGHTON CENTER	0	0			193.40
193.50 19305	WELLNESS CENTER	0	0			193.50
193.80 19308	UNUSED SPACE	0	0			193.80
193.90 19309	OCCUPATIONAL HEALTH	0	0			193.90
193.91 19310	RESEARCH AND PROTOCOL	0	0			193.91
193.92 19311	CCOP	0	0			193.92
193.93 19312	RESEARCH ADMIN	0	0			193.93
200.00	Cross Foot Adjustments			4,186	597,064	136,419 200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0058

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			16.00	17.00		
201.00   Negative Cost Centers	0	0	0	0	0	201.00
202.00   TOTAL (sum lines 118 through 201)	181,608	322,384	4,186	597,064	136,419	202.00

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/29/2019 8:36 am
Cost Center Description	PARAMED ED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	23.01	24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100						1.00
2.00 00200						2.00
4.00 00400						4.00
5.00 00500						5.00
6.00 00600						6.00
7.00 00700						7.00
8.00 00800						8.00
9.00 00900						9.00
10.00 01000						10.00
11.00 01100						11.00
13.00 01300						13.00
14.00 01400						14.00
15.00 01500						15.00
16.00 01600						16.00
17.00 01700						17.00
21.00 02100						21.00
22.00 02200						22.00
23.00 02300						23.00
23.01 02301	0					23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000		10,633,452	0	10,633,452		30.00
31.00 03100		1,329,024	0	1,329,024		31.00
31.01 02060		1,165,826	0	1,165,826		31.01
40.00 04000		570,167	0	570,167		40.00
41.00 04100		507,255	0	507,255		41.00
43.00 04300		194,109	0	194,109		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000		4,166,316	0	4,166,316		50.00
52.00 05200		1,412,088	0	1,412,088		52.00
54.00 05400		2,266,056	0	2,266,056		54.00
57.00 05700		109,228	0	109,228		57.00
58.00 05800		159,081	0	159,081		58.00
59.00 05900		578,661	0	578,661		59.00
60.00 06000		452,210	0	452,210		60.00
60.01 06001		0	0	0		60.01
65.00 06500		286,306	0	286,306		65.00
66.00 06600		511,628	0	511,628		66.00
66.01 06602		3,972	0	3,972		66.01
66.10 06601		1,530	0	1,530		66.10
67.00 06700		248,565	0	248,565		67.00
67.10 06701		1,019	0	1,019		67.10
68.00 06800		20,479	0	20,479		68.00
68.10 06801		684	0	684		68.10
70.00 07000		0	0	0		70.00
71.00 07100		725,710	0	725,710		71.00
72.00 07200		560,602	0	560,602		72.00
73.00 07300		506,090	0	506,090		73.00
76.00 03020		149,790	0	149,790		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000		0	0	0		90.00
90.10 09001		0	0	0		90.10
90.30 09002		383,663	0	383,663		90.30
90.50 09004		118,442	0	118,442		90.50
91.00 09100		1,443,509	0	1,443,509		91.00
92.00 09200			0			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300						113.00
118.00		0	0	0		118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000		173,301	0	173,301		190.00
193.00 19300		8,208,443	0	8,208,443		193.00
193.10 19301		12,839	0	12,839		193.10
193.40 19303		229,394	0	229,394		193.40
193.50 19305		10,028	0	10,028		193.50
193.80 19308		0	0	0		193.80
193.90 19309		0	0	0		193.90
193.91 19310		0	0	0		193.91
193.92 19311		0	0	0		193.92
193.93 19312		1,758	0	1,758		193.93
200.00		0	0	0		200.00
		737,669		737,669		

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0058

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		PARAMED ED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.01	24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	37,878,894	0	37,878,894		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0058

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

Worksheet B-1  
Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,252,910				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		1,252,910			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	223	223	147,016,688		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	22,678	22,678	5,617,663	-57,027,287	369,148,143
6.00 00600	MAINTENANCE & REPAIRS	3,022	3,022	555,770	0	4,709,998
7.00 00700	OPERATION OF PLANT	202,739	202,739	2,711,622	0	16,058,695
8.00 00800	LAUNDRY & LINEN SERVICE	151	151	0	0	1,587,917
9.00 00900	HOUSEKEEPING	21,792	21,792	3,033,360	0	6,232,918
10.00 01000	DIETARY	27,334	27,334	1,989,367	0	4,713,355
11.00 01100	CAFETERIA	4,641	4,641	1,352,307	0	1,185,331
13.00 01300	NURSING ADMINISTRATION	11,584	11,584	2,215,721	0	3,712,181
14.00 01400	CENTRAL SERVICES & SUPPLY	32,195	32,195	2,146,873	0	10,843,919
15.00 01500	PHARMACY	11,605	11,605	268,980	0	6,940,141
16.00 01600	MEDICAL RECORDS & LIBRARY	4,857	4,857	0	0	146,840
17.00 01700	SOCIAL SERVICE	8,443	8,443	2,999,090	0	4,653,905
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,938,385	0	2,204,961
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	15,984	15,984	3,283,210	0	6,202,007
23.00 02300	PARAMED ED PRGM-(SPECIFY)	3,721	3,721	91,164	0	263,742
23.01 02301	PARAMED ED	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	242,660	242,660	33,997,826	0	62,129,011
31.00 03100	INTENSIVE CARE UNIT	30,837	30,837	6,577,915	0	11,827,913
31.01 02060	NEONATAL INTENSIVE CARE UNIT	29,225	29,225	6,009,756	0	9,304,198
40.00 04000	SUBPROVIDER - I PF	12,683	12,683	1,092,684	0	2,001,276
41.00 04100	SUBPROVIDER - I RF	11,737	11,737	1,170,999	0	2,122,214
43.00 04300	NURSERY	4,565	4,565	1,361,810	0	2,057,407
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	106,714	106,714	14,116,007	0	34,678,973
52.00 05200	DELIVERY ROOM & LABOR ROOM	36,659	36,659	4,081,951	0	7,998,890
54.00 05400	RADIOLOGY-DIAGNOSTIC	58,614	58,614	8,825,535	0	17,138,786
57.00 05700	CT SCAN	2,850	2,850	1,172,498	0	2,085,649
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	4,315	4,315	0	0	1,209,080
59.00 05900	CARDIAC CATHETERIZATION	15,257	15,257	1,184,784	0	2,397,712
60.00 06000	LABORATORY	11,038	11,038	2,539,444	0	12,228,807
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	7,376	7,376	3,361,494	0	6,495,262
66.00 06600	PHYSICAL THERAPY	13,002	13,002	2,704,180	0	4,278,647
66.01 06602	PHYSICAL THERAPY EAST BANK	0	0	1,005,977	0	1,425,428
66.10 06601	PHYSICAL THERAPY LIVING CENTER	0	0	414,968	0	566,638
67.00 06700	OCCUPATIONAL THERAPY	6,464	6,464	1,778,480	0	2,594,300
67.10 06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	252,620	0	360,508
68.00 06800	SPEECH PATHOLOGY	395	395	986,825	0	1,364,609
68.10 06801	SPEECH THERAPY LIVING CENTER	0	0	182,367	0	254,074
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	10,311,293
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	26,351,594
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	6,283,247	0	33,740,817
76.00 03020	CARDIOLOGY	3,394	3,394	2,615,250	0	4,199,120
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0
90.10 09001	FAMILY PRACTICE CLINIC	0	0	0	0	0
90.30 09002	HEMATOLOGY ONCOLOGY CLINIC	10,112	10,112	755,091	0	1,410,426
90.50 09004	SLEEP DISORDERS CLINIC	3,187	3,187	599,431	0	1,001,209
91.00 09100	EMERGENCY	35,114	35,114	11,090,448	0	22,367,099
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,017,167	1,017,167	142,365,099	-57,027,287	353,356,850
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,761	4,761	0	0	143,938
193.00 19300	NONPAID WORKERS	224,680	224,680	301,909	0	7,517,942
193.10 19301	HEALTH PROPERTIES	0	0	2,221,706	0	4,271,021
193.40 19303	LEIGHTON CENTER	6,302	6,302	0	0	190,527
193.50 19305	WELLNESS CENTER	0	0	1,877,520	0	3,319,429
193.80 19308	UNUSED SPACE	0	0	0	0	0
193.90 19309	OCCUPATIONAL HEALTH	0	0	0	0	0
193.91 19310	RESEARCH AND PROTOCOL	0	0	0	0	0
193.92 19311	CCOP	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0058

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

Worksheet B-1

Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
193.93 19312 RESEARCH ADMIN	0	0	250,454	0	348,436	193.93	
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)	22,197,039	15,681,855	20,218,497		57,027,287	202.00	
203.00 Unit cost multiplier (Wkst. B, Part I)	17.716387	12.516346	0.137525		0.154483	203.00	
204.00 Cost to be allocated (per Wkst. B, Part II)			6,742		685,876	204.00	
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000046		0.001858	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: 15-0058

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

Worksheet B-1

Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	1,226,987				6.00
7.00	00700	OPERATION OF PLANT	202,739	1,024,248			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	151	151	996,243		8.00
9.00	00900	HOUSEKEEPING	21,792	21,792	0	95,681	9.00
10.00	01000	DIETARY	27,334	27,334	0	2,266	332,895
11.00	01100	CAFETERIA	4,641	4,641	0	0	0
13.00	01300	NURSING ADMINISTRATION	11,584	11,584	0	127	0
14.00	01400	CENTRAL SERVICES & SUPPLY	32,195	32,195	42	2,812	0
15.00	01500	PHARMACY	11,605	11,605	0	294	0
16.00	01600	MEDICAL RECORDS & LIBRARY	4,857	4,857	0	573	0
17.00	01700	SOCIAL SERVICE	8,443	8,443	0	186	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	15,984	15,984	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	3,721	3,721	63,717	0	0
23.01	02301	PARAMED ED	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	242,660	242,660	325,441	41,924	276,176
31.00	03100	INTENSIVE CARE UNIT	30,837	30,837	52	1,807	34,263
31.01	02060	NEONATAL INTENSIVE CARE UNIT	29,225	29,225	5,240	4,573	0
40.00	04000	SUBPROVIDER - I/PF	12,683	12,683	0	3,039	11,362
41.00	04100	SUBPROVIDER - I/RF	11,737	11,737	30,003	3,328	11,094
43.00	04300	NURSERY	4,565	4,565	1,713	1,778	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	106,714	106,714	305,207	12,399	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	36,659	36,659	64,225	4,059	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,614	58,614	84	5,159	0
57.00	05700	CT SCAN	2,850	2,850	43,710	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,315	4,315	49	0	0
59.00	05900	CARDIAC CATHETERIZATION	15,257	15,257	0	1,820	0
60.00	06000	LABORATORY	11,038	11,038	0	1,107	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	7,376	7,376	0	181	0
66.00	06600	PHYSICAL THERAPY	13,002	13,002	0	782	0
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	0	0
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	6,464	6,464	0	209	0
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	395	395	0	33	0
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	CARDIOLOGY	3,394	3,394	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	10,112	10,112	0	344	0
90.50	09004	SLEEP DISORDERS CLINIC	3,187	3,187	4	0	0
91.00	09100	EMERGENCY	35,114	35,114	156,756	3,605	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	991,244	788,505	996,243	92,405	332,895
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,761	4,761	0	0	0
193.00	19300	NONPAID WORKERS	224,680	224,680	0	3,276	0
193.10	19301	HEALTH PROPERTIES	0	0	0	0	0
193.40	19303	LEIGHTON CENTER	6,302	6,302	0	0	0
193.50	19305	WELLNESS CENTER	0	0	0	0	0
193.80	19308	UNUSED SPACE	0	0	0	0	0
193.90	19309	OCCUPATIONAL HEALTH	0	0	0	0	0
193.91	19310	RESEARCH AND PROTOCOL	0	0	0	0	0
193.92	19311	CCOP	0	0	0	0	0
193.93	19312	RESEARCH ADMIN	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0058

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

Worksheet B-1

Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	5,437,613	19,437,964	1,836,758	7,705,937	6,263,862	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	4.431679	18.977791	1.843685	80.537797	18.816329	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	100,140	6,175,863	8,437	803,730	1,021,312	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.081615	6.029656	0.008469	8.400100	3.067970	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: 15-0058

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

Worksheet B-1  
Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description		CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION  (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	4,182,238					11.00
13.00	01300	100,514	1,570,083				13.00
14.00	01400	103,338	18	100			14.00
15.00	01500	157,587	0	0	26,929,840		15.00
16.00	01600	0	0	0	0	3,195	16.00
17.00	01700	101,688	3,731	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	109,283	0	0	0	0	22.00
23.00	02300	3,172	69	0	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,207,601	678,192	0	3,092	523	30.00
31.00	03100	209,786	160,335	0	0	40	31.00
31.01	02060	151,258	125,766	0	3,458	14	31.01
40.00	04000	45,663	18,745	0	0	28	40.00
41.00	04100	36,249	23,228	0	0	13	41.00
43.00	04300	39,416	26,037	0	0	10	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	412,274	208,232	0	400	734	50.00
52.00	05200	124,551	88,145	0	61	0	52.00
54.00	05400	267,581	40,803	0	2,265	552	54.00
57.00	05700	32,507	64	0	0	0	57.00
58.00	05800	0	0	0	653	0	58.00
59.00	05900	31,056	11,191	0	383	0	59.00
60.00	06000	117,728	0	0	0	248	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	107,665	95	0	3,844	0	65.00
66.00	06600	70,587	7,049	0	12	345	66.00
66.01	06602	31,276	0	0	0	0	66.01
66.10	06601	11,196	0	0	0	0	66.10
67.00	06700	52,510	0	0	0	85	67.00
67.10	06701	8,250	0	0	0	0	67.10
68.00	06800	25,667	0	0	22	39	68.00
68.10	06801	4,991	0	0	0	0	68.10
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	58	0	0	71.00
72.00	07200	0	0	42	0	0	72.00
73.00	07300	0	0	0	26,900,728	0	73.00
76.00	03020	54,432	11,383	0	1,255	231	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.10	09001	0	0	0	0	0	90.10
90.30	09002	22,289	13,221	0	0	0	90.30
90.50	09004	17,728	0	0	0	0	90.50
91.00	09100	296,333	148,368	0	11,742	333	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00							118.00
		3,954,176	1,564,672	100	26,927,915	3,195	
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
193.00	19300	10,547	2,566	0	1,925	0	193.00
193.10	19301	117,347	17	0	0	0	193.10
193.40	19303	0	0	0	0	0	193.40
193.50	19305	92,355	0	0	0	0	193.50
193.80	19308	0	0	0	0	0	193.80
193.90	19309	0	0	0	0	0	193.90
193.91	19310	0	0	0	0	0	193.91
193.92	19311	0	0	0	0	0	193.92
193.93	19312	7,813	2,828	0	0	0	193.93
200.00							200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0058

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

Worksheet B-1

Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description		CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION  (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,477,087	4,602,554	13,535,887	8,363,277	329,372	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.353181	2.931408	135,358.870000	0.310558	103.089828	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	170,937	433,183	1,218,193	443,590	181,608	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.040872	0.275898	12,181.930000	0.016472	56.841315	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: 15-0058

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

Worksheet B-1

Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS		PARAMED PRGM (ASSIGNED TIME)	PARAMED (ASSIGNED TIME)	23.01
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
		17.00	21.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE	24,733					17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	2,716				21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0		2,716			22.00
23.00 02300 PARAMED PRGM-(SPECIFY)	0			100		23.00
23.01 02301 PARAMED ED	0				0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	17,551	1,763	1,763	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	815	8	8	0	0	31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	454	0	0	0	0	31.01
40.00 04000 SUBPROVIDER - IPF	2,795	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	446	0	0	0	0	41.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	4	102	102	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	50	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	506	13	13	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 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	34	34	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0	0	0	0	66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	66.10
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67.10
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
76.00 03020 RADIOLOGY	0	58	58	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	557	557	0	0	90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	464	4	4	0	0	90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0	0	0	0	90.50
91.00 09100 EMERGENCY	1,648	146	146	100	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	24,733	2,685	2,685	100	0 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
193.00 19300 NONPAID WORKERS	0	31	31	0	0	193.00
193.10 19301 HEALTH PROPERTIES	0	0	0	0	0	193.10
193.40 19303 LEIGHTON CENTER	0	0	0	0	0	193.40
193.50 19305 WELLNESS CENTER	0	0	0	0	0	193.50
193.80 19308 UNUSED SPACE	0	0	0	0	0	193.80
193.90 19309 OCCUPATIONAL HEALTH	0	0	0	0	0	193.90
193.91 19310 RESEARCH AND PROTOCOL	0	0	0	0	0	193.91
193.92 19311 CCOP	0	0	0	0	0	193.92
193.93 19312 RESEARCH ADMIN	0	0	0	0	0	193.93

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0058

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

Worksheet B-1  
Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS		PARAMED PRGM (ASSIGNED TIME)	PARAMED (ASSIGNED TIME)	
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
		17.00	21.00			
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)	5,632,331	2,545,590	7,572,886	510,388	0 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	227.725347	937.256996	2,788.249632	5,103.880000	0.000000 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	322,384	4,186	597,064	136,419	0 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	13.034569	1.541237	219.832106	1,364.190000	0.000000 205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0	0 206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000	0.000000 207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0058

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2019 8:36 am

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	93,046,953	93,046,953	20,864	93,067,817	30.00
31.00	03100 INTENSIVE CARE UNIT	15,901,153	15,901,153	154,553	16,055,706	31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT	12,331,636	12,331,636	6,766	12,338,402	31.01
40.00	04000 SUBPROVIDER - I PF	3,776,341	3,776,341	0	3,776,341	40.00
41.00	04100 SUBPROVIDER - I RF	3,440,710	3,440,710	0	3,440,710	41.00
43.00	04300 NURSERY	2,719,737	2,719,737	0	2,719,737	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	44,928,418	44,928,418	17,741	44,946,159	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10,851,848	10,851,848	30,336	10,882,184	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	21,961,161	21,961,161	39,612	22,000,773	54.00
57.00	05700 CT SCAN	2,566,819	2,566,819	0	2,566,819	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,497,167	1,497,167	0	1,497,167	58.00
59.00	05900 CARDIAC CATHETERIZATION	3,315,747	3,315,747	16,378	3,332,125	59.00
60.00	06000 LABORATORY	14,532,644	14,532,644	3,838	14,536,482	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	7,725,412	7,725,412	0	7,725,412	65.00
66.00	06600 PHYSICAL THERAPY	5,388,139	5,388,139	15,403	5,403,542	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	1,656,678	1,656,678	0	1,656,678	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	658,128	658,128	0	658,128	66.10
67.00	06700 OCCUPATIONAL THERAPY	3,190,534	3,190,534	0	3,190,534	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	419,114	419,114	0	419,114	67.10
68.00	06800 SPEECH PATHOLOGY	1,600,416	1,600,416	0	1,600,416	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	295,087	295,087	0	295,087	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19,755,026	19,755,026	0	19,755,026	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	36,107,540	36,107,540	0	36,107,540	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	47,307,435	47,307,435	0	47,307,435	73.00
76.00	03020 RADIOLOGY	5,004,061	5,004,061	63,738	5,067,799	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	2,045,027	2,045,027	3,498	2,048,525	90.30
90.50	09004 SLEEP DISORDERS CLINIC	1,236,753	1,236,753	18,827	1,255,580	90.50
91.00	09100 EMERGENCY	28,687,025	28,687,025	619,955	29,306,980	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	11,667,502	11,667,502	0	11,667,502	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	403,614,211	403,614,211	1,011,509	404,625,720	200.00
201.00	Less Observation Beds	11,667,502	11,667,502		11,667,502	201.00
202.00	Total (see instructions)	391,946,709	391,946,709	1,011,509	392,958,218	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0058		Period: From 01/01/2018 To 12/31/2018		Worksheet C Part I Date/Time Prepared: 5/29/2019 8:36 am		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	185,120,476		185,120,476				30.00
31.00	03100	INTENSIVE CARE UNIT	40,418,821		40,418,821				31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	27,793,839		27,793,839				31.01
40.00	04000	SUBPROVIDER - I/PF	3,753,254		3,753,254				40.00
41.00	04100	SUBPROVIDER - I/RF	7,672,079		7,672,079				41.00
43.00	04300	NURSERY	4,641,550		4,641,550				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	56,347,939	63,101,832	119,449,771	0.376128	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,027,855	1,667,645	19,695,500	0.550981	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,514,568	88,787,778	124,302,346	0.176675	0.000000		54.00
57.00	05700	CT SCAN	23,729,228	45,688,651	69,417,879	0.036976	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,087,434	1,230,455	5,317,889	0.281534	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	11,733,740	17,022,578	28,756,318	0.115305	0.000000		59.00
60.00	06000	LABORATORY	86,803,232	50,351,552	137,154,784	0.105958	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	39,122,895	3,590,182	42,713,077	0.180868	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	6,905,631	5,999,002	12,904,633	0.417535	0.000000		66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	2,081	4,028,312	4,030,393	0.411046	0.000000		66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	1,555	1,633,752	1,635,307	0.402449	0.000000		66.10
67.00	06700	OCCUPATIONAL THERAPY	4,926,995	2,150,359	7,077,354	0.450809	0.000000		67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	1,295	1,152,924	1,154,219	0.363115	0.000000		67.10
68.00	06800	SPEECH PATHOLOGY	2,389,898	1,965,374	4,355,272	0.367466	0.000000		68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	401	950,806	951,207	0.310224	0.000000		68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	80,454,619	49,273,334	129,727,953	0.152280	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	112,140,421	58,261,818	170,402,239	0.211896	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	116,963,371	129,521,180	246,484,551	0.191929	0.000000		73.00
76.00	03020	CARDIOLOGY	8,554,784	7,292,720	15,847,504	0.315763	0.000000		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.00	09000	CLINIC	0	0	0	0.000000	0.000000		90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0.000000	0.000000		90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	21,821	933,627	955,448	2.140385	0.000000		90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	4,265,617	4,265,617	0.289935	0.000000		90.50
91.00	09100	EMERGENCY	17,032,562	39,349,781	56,382,343	0.508794	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	34,980,979	34,980,979	0.333538	0.000000		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	894,162,344	613,200,258	1,507,362,602				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	894,162,344	613,200,258	1,507,362,602				202.00



COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 8:36 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT			31.01
40.00	04000 SUBPROVIDER - I PF			40.00
41.00	04100 SUBPROVIDER - I RF			41.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.376277		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.552521		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.176994		54.00
57.00	05700 CT SCAN	0.036976		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.281534		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.115875		59.00
60.00	06000 LABORATORY	0.105986		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.180868		65.00
66.00	06600 PHYSICAL THERAPY	0.418729		66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.411046		66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.402449		66.10
67.00	06700 OCCUPATIONAL THERAPY	0.450809		67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.363115		67.10
68.00	06800 SPEECH PATHOLOGY	0.367466		68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.310224		68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152280		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.211896		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.191929		73.00
76.00	03020 CARDIOLOGY	0.319785		76.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000		90.00
90.10	09001 FAMILY PRACTICE CLINIC	0.000000		90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	2.144047		90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.294349		90.50
91.00	09100 EMERGENCY	0.519790		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.333538		92.00
	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: 15-0058

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2019 8:36 am

		Title XIX		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	93,046,953		93,046,953	20,864	93,067,817	30.00
31.00	03100	INTENSIVE CARE UNIT	15,901,153		15,901,153	154,553	16,055,706	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	12,331,636		12,331,636	6,766	12,338,402	31.01
40.00	04000	SUBPROVIDER - I PF	3,776,341		3,776,341	0	3,776,341	40.00
41.00	04100	SUBPROVIDER - I RF	3,440,710		3,440,710	0	3,440,710	41.00
43.00	04300	NURSERY	2,719,737		2,719,737	0	2,719,737	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	44,928,418		44,928,418	17,741	44,946,159	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,851,848		10,851,848	30,336	10,882,184	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,961,161		21,961,161	39,612	22,000,773	54.00
57.00	05700	CT SCAN	2,566,819		2,566,819	0	2,566,819	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,497,167		1,497,167	0	1,497,167	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,315,747		3,315,747	16,378	3,332,125	59.00
60.00	06000	LABORATORY	14,532,644		14,532,644	3,838	14,536,482	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	7,725,412	0	7,725,412	0	7,725,412	65.00
66.00	06600	PHYSICAL THERAPY	5,388,139	0	5,388,139	15,403	5,403,542	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	1,656,678	0	1,656,678	0	1,656,678	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	658,128	0	658,128	0	658,128	66.10
67.00	06700	OCCUPATIONAL THERAPY	3,190,534	0	3,190,534	0	3,190,534	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	419,114	0	419,114	0	419,114	67.10
68.00	06800	SPEECH PATHOLOGY	1,600,416	0	1,600,416	0	1,600,416	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	295,087	0	295,087	0	295,087	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,755,026		19,755,026	0	19,755,026	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,107,540		36,107,540	0	36,107,540	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,307,435		47,307,435	0	47,307,435	73.00
76.00	03020	CARDIOLOGY	5,004,061		5,004,061	63,738	5,067,799	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0		0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0		0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	2,045,027		2,045,027	3,498	2,048,525	90.30
90.50	09004	SLEEP DISORDERS CLINIC	1,236,753		1,236,753	18,827	1,255,580	90.50
91.00	09100	EMERGENCY	28,687,025		28,687,025	619,955	29,306,980	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	11,667,502		11,667,502		11,667,502	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	403,614,211	0	403,614,211	1,011,509	404,625,720	200.00
201.00		Less Observation Beds	11,667,502		11,667,502		11,667,502	201.00
202.00		Total (see instructions)	391,946,709	0	391,946,709	1,011,509	392,958,218	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0058		Period: From 01/01/2018 To 12/31/2018		Worksheet C Part I Date/Time Prepared: 5/29/2019 8:36 am		
			Title XIX			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	185,120,476		185,120,476				30.00
31.00	03100	INTENSIVE CARE UNIT	40,418,821		40,418,821				31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	27,793,839		27,793,839				31.01
40.00	04000	SUBPROVIDER - I/PF	3,753,254		3,753,254				40.00
41.00	04100	SUBPROVIDER - I/RF	7,672,079		7,672,079				41.00
43.00	04300	NURSERY	4,641,550		4,641,550				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	56,347,939	63,101,832	119,449,771	0.376128	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,027,855	1,667,645	19,695,500	0.550981	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,514,568	88,787,778	124,302,346	0.176675	0.000000		54.00
57.00	05700	CT SCAN	23,729,228	45,688,651	69,417,879	0.036976	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,087,434	1,230,455	5,317,889	0.281534	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	11,733,740	17,022,578	28,756,318	0.115305	0.000000		59.00
60.00	06000	LABORATORY	86,803,232	50,351,552	137,154,784	0.105958	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	39,122,895	3,590,182	42,713,077	0.180868	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	6,905,631	5,999,002	12,904,633	0.417535	0.000000		66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	2,081	4,028,312	4,030,393	0.411046	0.000000		66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	1,555	1,633,752	1,635,307	0.402449	0.000000		66.10
67.00	06700	OCCUPATIONAL THERAPY	4,926,995	2,150,359	7,077,354	0.450809	0.000000		67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	1,295	1,152,924	1,154,219	0.363115	0.000000		67.10
68.00	06800	SPEECH PATHOLOGY	2,389,898	1,965,374	4,355,272	0.367466	0.000000		68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	401	950,806	951,207	0.310224	0.000000		68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	80,454,619	49,273,334	129,727,953	0.152280	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	112,140,421	58,261,818	170,402,239	0.211896	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	116,963,371	129,521,180	246,484,551	0.191929	0.000000		73.00
76.00	03020	CARDIOLOGY	8,554,784	7,292,720	15,847,504	0.315763	0.000000		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.00	09000	CLINIC	0	0	0	0.000000	0.000000		90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0.000000	0.000000		90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	21,821	933,627	955,448	2.140385	0.000000		90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	4,265,617	4,265,617	0.289935	0.000000		90.50
91.00	09100	EMERGENCY	17,032,562	39,349,781	56,382,343	0.508794	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	34,980,979	34,980,979	0.333538	0.000000		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	894,162,344	613,200,258	1,507,362,602				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	894,162,344	613,200,258	1,507,362,602				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 8:36 am
Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital PPS
		INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT			31.01
40.00	04000	SUBPROVIDER - I PF			40.00
41.00	04100	SUBPROVIDER - I RF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.376277		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.552521		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176994		54.00
57.00	05700	CT SCAN	0.036976		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.281534		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.115875		59.00
60.00	06000	LABORATORY	0.105986		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.180868		65.00
66.00	06600	PHYSICAL THERAPY	0.418729		66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.411046		66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.402449		66.10
67.00	06700	OCCUPATIONAL THERAPY	0.450809		67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.363115		67.10
68.00	06800	SPEECH PATHOLOGY	0.367466		68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.310224		68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152280		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.211896		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.191929		73.00
76.00	03020	CARDIOLOGY	0.319785		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000		90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	2.144047		90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.294349		90.50
91.00	09100	EMERGENCY	0.519790		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.333538		92.00
		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

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

Provider CCN: 15-0058

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

Worksheet C Part II Date/Time Prepared: 5/29/2019 8:36 am

Cost Center Description		Title XIX			Hospital	PPS		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	44,928,418	4,166,316	40,762,102	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,851,848	1,412,088	9,439,760	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,961,161	2,266,056	19,695,105	0	0	54.00
57.00	05700	CT SCAN	2,566,819	109,228	2,457,591	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,497,167	159,081	1,338,086	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,315,747	578,661	2,737,086	0	0	59.00
60.00	06000	LABORATORY	14,532,644	452,210	14,080,434	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	7,725,412	286,306	7,439,106	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,388,139	511,628	4,876,511	0	0	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	1,656,678	3,972	1,652,706	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	658,128	1,530	656,598	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	3,190,534	248,565	2,941,969	0	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	419,114	1,019	418,095	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	1,600,416	20,479	1,579,937	0	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	295,087	684	294,403	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,755,026	725,710	19,029,316	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,107,540	560,602	35,546,938	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,307,435	506,090	46,801,345	0	0	73.00
76.00	03020	CARDIOLOGY	5,004,061	149,790	4,854,271	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	2,045,027	383,663	1,661,364	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	1,236,753	118,442	1,118,311	0	0	90.50
91.00	09100	EMERGENCY	28,687,025	1,443,509	27,243,516	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	11,667,502	1,333,070	10,334,432	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	272,397,681	15,438,699	256,958,982	0	0	200.00
201.00		Less Observation Beds	11,667,502	1,333,070	10,334,432	0	0	201.00
202.00		Total (line 200 minus line 201)	260,730,179	14,105,629	246,624,550	0	0	202.00

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

Provider CCN: 15-0058

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

Worksheet C Part II Date/Time Prepared: 5/29/2019 8:36 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	44,928,418	119,449,771	0.376128	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10,851,848	19,695,500	0.550981	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	21,961,161	124,302,346	0.176675	54.00
57.00	05700 CT SCAN	2,566,819	69,417,879	0.036976	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,497,167	5,317,889	0.281534	58.00
59.00	05900 CARDIAC CATHETERIZATION	3,315,747	28,756,318	0.115305	59.00
60.00	06000 LABORATORY	14,532,644	137,154,784	0.105958	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	60.01
65.00	06500 RESPIRATORY THERAPY	7,725,412	42,713,077	0.180868	65.00
66.00	06600 PHYSICAL THERAPY	5,388,139	12,904,633	0.417535	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	1,656,678	4,030,393	0.411046	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	658,128	1,635,307	0.402449	66.10
67.00	06700 OCCUPATIONAL THERAPY	3,190,534	7,077,354	0.450809	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	419,114	1,154,219	0.363115	67.10
68.00	06800 SPEECH PATHOLOGY	1,600,416	4,355,272	0.367466	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	295,087	951,207	0.310224	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19,755,026	129,727,953	0.152280	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	36,107,540	170,402,239	0.211896	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	47,307,435	246,484,551	0.191929	73.00
76.00	03020 CARDIOLOGY	5,004,061	15,847,504	0.315763	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0.000000	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0.000000	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	2,045,027	955,448	2.140385	90.30
90.50	09004 SLEEP DISORDERS CLINIC	1,236,753	4,265,617	0.289935	90.50
91.00	09100 EMERGENCY	28,687,025	56,382,343	0.508794	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	11,667,502	34,980,979	0.333538	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	272,397,681	1,237,962,583		200.00
201.00	Less Observation Beds	11,667,502	0		201.00
202.00	Total (line 200 minus line 201)	260,730,179	1,237,962,583		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part I Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,633,452	0	10,633,452	83,883	126.77	30.00
31.00	INTENSIVE CARE UNIT	1,329,024		1,329,024	9,208	144.33	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	1,165,826		1,165,826	8,919	130.71	31.01
40.00	SUBPROVIDER - IPF	570,167	0	570,167	3,090	184.52	40.00
41.00	SUBPROVIDER - IRF	507,255	0	507,255	2,907	174.49	41.00
43.00	NURSERY	194,109		194,109	4,201	46.21	43.00
200.00	Total (lines 30 through 199)	14,399,833		14,399,833	112,208		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	23,916	3,031,831				
31.00	INTENSIVE CARE UNIT	2,261	326,330				
31.01	NEONATAL INTENSIVE CARE UNIT	0	0				
40.00	SUBPROVIDER - IPF	993	183,228				
41.00	SUBPROVIDER - IRF	1,180	205,898				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	28,350	3,747,287				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital 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	4,166,316	119,449,771	0.034879	20,437,219	712,830	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,412,088	19,695,500	0.071696	26,947	1,932	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,266,056	124,302,346	0.018230	12,337,795	224,918	54.00
57.00	05700	CT SCAN	109,228	69,417,879	0.001573	7,724,597	12,151	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	159,081	5,317,889	0.029914	1,468,405	43,926	58.00
59.00	05900	CARDIAC CATHETERIZATION	578,661	28,756,318	0.020123	4,772,811	96,043	59.00
60.00	06000	LABORATORY	452,210	137,154,784	0.003297	27,799,529	91,655	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	286,306	42,713,077	0.006703	12,406,538	83,161	65.00
66.00	06600	PHYSICAL THERAPY	511,628	12,904,633	0.039647	2,117,613	83,957	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	3,972	4,030,393	0.000986	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	1,530	1,635,307	0.000936	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	248,565	7,077,354	0.035121	1,119,458	39,316	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	1,019	1,154,219	0.000883	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	20,479	4,355,272	0.004702	529,098	2,488	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	684	951,207	0.000719	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	725,710	129,727,953	0.005594	24,822,388	138,856	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	560,602	170,402,239	0.003290	42,078,575	138,439	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	506,090	246,484,551	0.002053	41,613,444	85,432	73.00
76.00	03020	CARDIOLOGY	149,790	15,847,504	0.009452	3,079,544	29,108	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	383,663	955,448	0.401553	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	118,442	4,265,617	0.027767	0	0	90.50
91.00	09100	EMERGENCY	1,443,509	56,382,343	0.025602	6,112,917	156,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,333,070	34,980,979	0.038108	0	0	92.00
200.00		Total (lines 50 through 199)	15,438,699	1,237,962,583		208,446,878	1,940,715	200.00



APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
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	83,883	0.00	23,916	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	9,208	0.00	2,261	31.00	
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	8,919	0.00	0	31.01	
40.00	04000	SUBPROVIDER - IPF	0	0	3,090	0.00	993	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	2,907	0.00	1,180	41.00	
43.00	04300	NURSERY	0	0	4,201	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	112,208	0.00	28,350	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0						31.01
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
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: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description	Title XVIII			Hospital		PPS		
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health			
	1.00	2A	2.00	3A	3.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
76.00	03020	CARDIOLOGY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	0	0	0	0	90.50
91.00	09100	EMERGENCY	0	0	0	0	510,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	510,388	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description		Title XVIII			Hospital		PPS	
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	119,449,771	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	19,695,500	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	124,302,346	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	69,417,879	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,317,889	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	28,756,318	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	137,154,784	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	42,713,077	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,904,633	0.000000	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	4,030,393	0.000000	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	1,635,307	0.000000	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,077,354	0.000000	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	1,154,219	0.000000	67.10
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,355,272	0.000000	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	951,207	0.000000	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	129,727,953	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	170,402,239	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	246,484,551	0.000000	73.00
76.00	03020	CARDIOLOGY	0	0	0	15,847,504	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	0	0	955,448	0.000000	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	0	0	4,265,617	0.000000	90.50
91.00	09100	EMERGENCY	0	510,388	510,388	56,382,343	0.009052	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	34,980,979	0.000000	92.00
200.00		Total (lines 50 through 199)	0	510,388	510,388	1,237,962,583		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description		Title XVIII				Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	20,437,219	0	14,931,158	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	26,947	0	686	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	12,337,795	0	26,353,073	0	54.00
57.00	05700	CT SCAN	0.000000	7,724,597	0	10,953,712	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	1,468,405	0	286,238	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	4,772,811	0	6,233,113	0	59.00
60.00	06000	LABORATORY	0.000000	27,799,529	0	9,853,889	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	12,406,538	0	727,278	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,117,613	0	1,559,386	0	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.000000	0	0	63,419	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.000000	0	0	38,405	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,119,458	0	71,870	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.000000	0	0	54,357	0	67.10
68.00	06800	SPEECH PATHOLOGY	0.000000	529,098	0	10,709	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.000000	0	0	14,054	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	24,822,388	0	11,359,531	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	42,078,575	0	18,248,117	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	41,613,444	0	44,080,782	0	73.00
76.00	03020	CARDIOLOGY	0.000000	3,079,544	0	2,043,899	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0.000000	0	0	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.000000	0	0	625,936	0	90.50
91.00	09100	EMERGENCY	0.009052	6,112,917	55,334	5,852,222	52,974	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	3,908,011	0	92.00
200.00		Total (lines 50 through 199)		208,446,878	55,334	157,269,845	52,974	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 8:36 am
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		Title XVIII			Hospital	PPS	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.376128	14,931,158	0	0	5,616,027	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.550981	686	0	0	378	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.176675	26,353,073	0	0	4,655,929	54.00
57.00	05700 CT SCAN	0.036976	10,953,712	0	0	405,024	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.281534	286,238	0	0	80,586	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.115305	6,233,113	0	0	718,709	59.00
60.00	06000 LABORATORY	0.105958	9,853,889	0	0	1,044,098	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.180868	727,278	0	0	131,541	65.00
66.00	06600 PHYSICAL THERAPY	0.417535	1,559,386	0	0	651,098	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.411046	63,419	0	0	26,068	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.402449	38,405	0	0	15,456	66.10
67.00	06700 OCCUPATIONAL THERAPY	0.450809	71,870	0	0	32,400	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.363115	54,357	0	0	19,738	67.10
68.00	06800 SPEECH PATHOLOGY	0.367466	10,709	0	0	3,935	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.310224	14,054	0	0	4,360	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152280	11,359,531	640	0	1,729,829	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.211896	18,248,117	0	0	3,866,703	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.191929	44,080,782	0	0	8,460,380	73.00
76.00	03020 RADIOLOGY	0.315763	2,043,899	0	0	645,388	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	2.140385	0	0	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.289935	625,936	0	0	181,481	90.50
91.00	09100 EMERGENCY	0.508794	5,852,222	0	0	2,977,575	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.333538	3,908,011	0	0	1,303,470	92.00
200.00	Subtotal (see instructions)		157,269,845	640	0	32,570,173	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		157,269,845	640	0	32,570,173	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 8:36 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
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 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0		66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0		66.10
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0		67.10
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0		68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	97	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00 03020 RADIOLOGY	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0		90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0		90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0		90.50
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	97	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 - line 201)	97	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0058 Component CCN: 15-S058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/29/2019 8:36 am
Title XVIII			Subprovider - IPF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,166,316	119,449,771	0.034879	157,725	5,501	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,412,088	19,695,500	0.071696	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,266,056	124,302,346	0.018230	7,833	143	54.00
57.00	05700	CT SCAN	109,228	69,417,879	0.001573	6,204	10	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	159,081	5,317,889	0.029914	5,739	172	58.00
59.00	05900	CARDIAC CATHETERIZATION	578,661	28,756,318	0.020123	0	0	59.00
60.00	06000	LABORATORY	452,210	137,154,784	0.003297	123,093	406	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	286,306	42,713,077	0.006703	0	0	65.00
66.00	06600	PHYSICAL THERAPY	511,628	12,904,633	0.039647	105,134	4,168	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	3,972	4,030,393	0.000986	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	1,530	1,635,307	0.000936	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	248,565	7,077,354	0.035121	34,712	1,219	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	1,019	1,154,219	0.000883	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	20,479	4,355,272	0.004702	226	1	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	684	951,207	0.000719	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	725,710	129,727,953	0.005594	2,176	12	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	560,602	170,402,239	0.003290	1,740	6	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	506,090	246,484,551	0.002053	458,887	942	73.00
76.00	03020	CARDIOLOGY	149,790	15,847,504	0.009452	150	1	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	383,663	955,448	0.401553	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	118,442	4,265,617	0.027767	0	0	90.50
91.00	09100	EMERGENCY	1,443,509	56,382,343	0.025602	2,039	52	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	34,980,979	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	14,105,629	1,237,962,583		905,658	12,633	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-S058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0	0	0	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
76.00	03020 CARDIOLOGY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0	0	0	0	0	90.50
91.00	09100 EMERGENCY	0	0	0	0	510,388	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	510,388	200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-S058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	119,449,771	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	19,695,500	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	124,302,346	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	69,417,879	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,317,889	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	28,756,318	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	137,154,784	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	42,713,077	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,904,633	0.000000	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	4,030,393	0.000000	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	1,635,307	0.000000	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,077,354	0.000000	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	1,154,219	0.000000	67.10
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,355,272	0.000000	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	951,207	0.000000	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	129,727,953	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	170,402,239	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	246,484,551	0.000000	73.00
76.00	03020	CARDIOLOGY	0	0	0	15,847,504	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	0	0	955,448	0.000000	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	0	0	4,265,617	0.000000	90.50
91.00	09100	EMERGENCY	0	510,388	510,388	56,382,343	0.009052	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	34,980,979	0.000000	92.00
200.00		Total (lines 50 through 199)	0	510,388	510,388	1,237,962,583		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-S058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
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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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	157,725	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	7,833	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	6,204	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	5,739	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	123,093	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	105,134	0	0	0	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.000000	0	0	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.000000	0	0	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0.000000	34,712	0	0	0	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.000000	0	0	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0.000000	226	0	0	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.000000	0	0	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,176	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,740	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	458,887	0	0	0	73.00
76.00	03020 CARDIOLOGY	0.000000	150	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0.000000	0	0	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.000000	0	0	0	0	90.50
91.00	09100 EMERGENCY	0.009052	2,039	18	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		905,658	18	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/29/2019 8:36 am
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	4,166,316	119,449,771	0.034879	3,283	115	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,412,088	19,695,500	0.071696	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,266,056	124,302,346	0.018230	94,774	1,728	54.00
57.00	05700 CT SCAN	109,228	69,417,879	0.001573	33,839	53	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	159,081	5,317,889	0.029914	10,622	318	58.00
59.00	05900 CARDIAC CATHETERIZATION	578,661	28,756,318	0.020123	0	0	59.00
60.00	06000 LABORATORY	452,210	137,154,784	0.003297	192,559	635	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	286,306	42,713,077	0.006703	160,787	1,078	65.00
66.00	06600 PHYSICAL THERAPY	511,628	12,904,633	0.039647	527,105	20,898	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	3,972	4,030,393	0.000986	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	1,530	1,635,307	0.000936	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	248,565	7,077,354	0.035121	503,569	17,686	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	1,019	1,154,219	0.000883	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	20,479	4,355,272	0.004702	325,614	1,531	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	684	951,207	0.000719	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	725,710	129,727,953	0.005594	94,664	530	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	560,602	170,402,239	0.003290	11,440	38	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	506,090	246,484,551	0.002053	596,767	1,225	73.00
76.00	03020 CARDIOLOGY	149,790	15,847,504	0.009452	3,249	31	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	383,663	955,448	0.401553	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	118,442	4,265,617	0.027767	0	0	90.50
91.00	09100 EMERGENCY	1,443,509	56,382,343	0.025602	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	34,980,979	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	14,105,629	1,237,962,583		2,558,272	45,866	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0	0	0	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
76.00	03020 CARDIOLOGY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0	0	0	0	0	90.50
91.00	09100 EMERGENCY	0	0	0	0	510,388	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	510,388	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	
	4.00	5.00	6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	119,449,771	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	19,695,500	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	124,302,346	0.000000	54.00
57.00 05700 CT SCAN	0	0	0	69,417,879	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,317,889	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	28,756,318	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	137,154,784	0.000000	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	0	42,713,077	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	12,904,633	0.000000	66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0	0	4,030,393	0.000000	66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	1,635,307	0.000000	66.10
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	7,077,354	0.000000	67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	1,154,219	0.000000	67.10
68.00 06800 SPEECH PATHOLOGY	0	0	0	4,355,272	0.000000	68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0	0	951,207	0.000000	68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	129,727,953	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	170,402,239	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	246,484,551	0.000000	73.00
76.00 03020 RADIOLOGY	0	0	0	15,847,504	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	955,448	0.000000	90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0	0	4,265,617	0.000000	90.50
91.00 09100 EMERGENCY	0	510,388	510,388	56,382,343	0.009052	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	34,980,979	0.000000	92.00
200.00 Total (lines 50 through 199)	0	510,388	510,388	1,237,962,583		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
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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	3,283	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	94,774	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	33,839	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	10,622	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	192,559	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.000000	160,787	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	527,105	0	0	0	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.000000	0	0	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.000000	0	0	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0.000000	503,569	0	0	0	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.000000	0	0	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0.000000	325,614	0	0	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.000000	0	0	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	94,664	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	11,440	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	596,767	0	0	0	73.00
76.00	03020 CARDIOLOGY	0.000000	3,249	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0.000000	0	0	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.000000	0	0	0	0	90.50
91.00	09100 EMERGENCY	0.009052	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		2,558,272	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part I Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description		Title XIX			Hospital	PPS		
		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	10,633,452	0	10,633,452	83,883	126.77	30.00	
31.00	INTENSIVE CARE UNIT	1,329,024		1,329,024	9,208	144.33	31.00	
31.01	NEONATAL INTENSIVE CARE UNIT	1,165,826		1,165,826	8,919	130.71	31.01	
40.00	SUBPROVIDER - IPF	570,167	0	570,167	3,090	184.52	40.00	
41.00	SUBPROVIDER - IRF	507,255	0	507,255	2,907	174.49	41.00	
43.00	NURSERY	194,109		194,109	4,201	46.21	43.00	
200.00	Total (lines 30 through 199)	14,399,833		14,399,833	112,208		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,501	317,052					30.00
31.00	INTENSIVE CARE UNIT	0	0					31.00
31.01	NEONATAL INTENSIVE CARE UNIT	338	44,180					31.01
40.00	SUBPROVIDER - IPF	65	11,994					40.00
41.00	SUBPROVIDER - IRF	11	1,919					41.00
43.00	NURSERY	161	7,440					43.00
200.00	Total (lines 30 through 199)	3,076	382,585					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,166,316	119,449,771	0.034879	19,880,836	693,424	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,412,088	19,695,500	0.071696	9,945,694	713,066	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,266,056	124,302,346	0.018230	7,923,242	144,441	54.00
57.00	05700	CT SCAN	109,228	69,417,879	0.001573	4,121,914	6,484	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	159,081	5,317,889	0.029914	835,083	24,981	58.00
59.00	05900	CARDIAC CATHETERIZATION	578,661	28,756,318	0.020123	1,881,745	37,866	59.00
60.00	06000	LABORATORY	452,210	137,154,784	0.003297	20,706,816	68,270	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	286,306	42,713,077	0.006703	11,147,461	74,721	65.00
66.00	06600	PHYSICAL THERAPY	511,628	12,904,633	0.039647	931,446	36,929	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	3,972	4,030,393	0.000986	679	1	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	1,530	1,635,307	0.000936	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	248,565	7,077,354	0.035121	690,072	24,236	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	1,019	1,154,219	0.000883	499	0	67.10
68.00	06800	SPEECH PATHOLOGY	20,479	4,355,272	0.004702	308,518	1,451	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	684	951,207	0.000719	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	725,710	129,727,953	0.005594	343,946	1,924	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	560,602	170,402,239	0.003290	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	506,090	246,484,551	0.002053	24,404,432	50,102	73.00
76.00	03020	CARDIOLOGY	149,790	15,847,504	0.009452	1,187,310	11,222	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	383,663	955,448	0.401553	16,448	6,605	90.30
90.50	09004	SLEEP DISORDERS CLINIC	118,442	4,265,617	0.027767	0	0	90.50
91.00	09100	EMERGENCY	1,443,509	56,382,343	0.025602	4,546,775	116,407	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,333,070	34,980,979	0.038108	0	0	92.00
200.00		Total (lines 50 through 199)	15,438,699	1,237,962,583		108,872,916	2,012,130	200.00



APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS			1A	1.00	2A	2.00	3.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
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		
INPATIENT ROUTINE SERVICE COST CENTERS			4.00	5.00	6.00	7.00	8.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	83,883	0.00	2,501	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	9,208	0.00	0	31.00	
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	8,919	0.00	338	31.01	
40.00	04000	SUBPROVIDER - IPF	0	0	3,090	0.00	65	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	2,907	0.00	11	41.00	
43.00	04300	NURSERY	0	0	4,201	0.00	161	43.00	
200.00		Total (lines 30 through 199)	0	0	112,208	0.00	3,076	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
INPATIENT ROUTINE SERVICE COST CENTERS			9.00						
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0						31.01
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
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: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description	Title XIX				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0	0	0	0	0	66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	0	66.10
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	0	67.10
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0	0	0	0	0	68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00 03020 RADIOLOGY	0	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0	0	0	0	0	90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	0	0	90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0	0	0	0	0	90.50
91.00 09100 EMERGENCY	0	0	0	0	0	510,388	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	510,388	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description		Title XIX				Hospital	PPS	
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	119,449,771	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	19,695,500	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	124,302,346	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	69,417,879	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,317,889	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	28,756,318	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	137,154,784	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	42,713,077	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,904,633	0.000000	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	4,030,393	0.000000	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	1,635,307	0.000000	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,077,354	0.000000	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	1,154,219	0.000000	67.10
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,355,272	0.000000	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	951,207	0.000000	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	129,727,953	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	170,402,239	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	246,484,551	0.000000	73.00
76.00	03020	CARDIOLOGY	0	0	0	15,847,504	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	0	0	955,448	0.000000	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	0	0	4,265,617	0.000000	90.50
91.00	09100	EMERGENCY	0	510,388	510,388	56,382,343	0.009052	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	34,980,979	0.000000	92.00
200.00		Total (lines 50 through 199)	0	510,388	510,388	1,237,962,583		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description		Title XIX			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	19,880,836	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	9,945,694	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	7,923,242	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	4,121,914	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	835,083	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	1,881,745	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	20,706,816	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.000000	11,147,461	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	931,446	0	0	0	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.000000	679	0	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.000000	0	0	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0.000000	690,072	0	0	0	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.000000	499	0	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0.000000	308,518	0	0	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.000000	0	0	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	343,946	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	24,404,432	0	0	0	73.00
76.00	03020 CARDIOLOGY	0.000000	1,187,310	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0.000000	16,448	0	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.000000	0	0	0	0	90.50
91.00	09100 EMERGENCY	0.009052	4,546,775	41,157	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		108,872,916	41,157	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0058 Component CCN: 15-S058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/29/2019 8:36 am
Title XIX			Subprovider - IPF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,166,316	119,449,771	0.034879	23,950	835	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,412,088	19,695,500	0.071696	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,266,056	124,302,346	0.018230	3,696	67	54.00
57.00	05700 CT SCAN	109,228	69,417,879	0.001573	2,068	3	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	159,081	5,317,889	0.029914	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	578,661	28,756,318	0.020123	0	0	59.00
60.00	06000 LABORATORY	452,210	137,154,784	0.003297	72,750	240	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	286,306	42,713,077	0.006703	5,425	36	65.00
66.00	06600 PHYSICAL THERAPY	511,628	12,904,633	0.039647	37,027	1,468	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	3,972	4,030,393	0.000986	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	1,530	1,635,307	0.000936	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	248,565	7,077,354	0.035121	25,497	895	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	1,019	1,154,219	0.000883	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	20,479	4,355,272	0.004702	0	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	684	951,207	0.000719	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	725,710	129,727,953	0.005594	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	560,602	170,402,239	0.003290	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	506,090	246,484,551	0.002053	190,138	390	73.00
76.00	03020 CARDIOLOGY	149,790	15,847,504	0.009452	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	383,663	955,448	0.401553	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	118,442	4,265,617	0.027767	0	0	90.50
91.00	09100 EMERGENCY	1,443,509	56,382,343	0.025602	12,977	332	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	34,980,979	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	14,105,629	1,237,962,583		373,528	4,266	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-S058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
	Title XIX	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0	0	0	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
76.00	03020 CARDIOLOGY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0	0	0	0	0	90.50
91.00	09100 EMERGENCY	0	0	0	0	510,388	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	510,388	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-S058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
Title XIX		Subprovider - IPF	PPS

Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	
	4.00	5.00	6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	119,449,771	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	19,695,500	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	124,302,346	0.000000	54.00
57.00 05700 CT SCAN	0	0	0	69,417,879	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,317,889	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	28,756,318	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	137,154,784	0.000000	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	0	42,713,077	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	12,904,633	0.000000	66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0	0	4,030,393	0.000000	66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	1,635,307	0.000000	66.10
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	7,077,354	0.000000	67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	1,154,219	0.000000	67.10
68.00 06800 SPEECH PATHOLOGY	0	0	0	4,355,272	0.000000	68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0	0	951,207	0.000000	68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	129,727,953	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	170,402,239	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	246,484,551	0.000000	73.00
76.00 03020 RADIOLOGY	0	0	0	15,847,504	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	955,448	0.000000	90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0	0	4,265,617	0.000000	90.50
91.00 09100 EMERGENCY	0	510,388	510,388	56,382,343	0.009052	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	34,980,979	0.000000	92.00
200.00 Total (lines 50 through 199)	0	510,388	510,388	1,237,962,583		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-S058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
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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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	23,950	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	3,696	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	2,068	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	72,750	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.000000	5,425	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	37,027	0	0	0	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.000000	0	0	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.000000	0	0	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0.000000	25,497	0	0	0	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.000000	0	0	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.000000	0	0	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
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	190,138	0	0	0	73.00
76.00	03020 CARDIOLOGY	0.000000	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0.000000	0	0	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.000000	0	0	0	0	90.50
91.00	09100 EMERGENCY	0.009052	12,977	117	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		373,528	117	0	0	200.00



APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/29/2019 8:36 am
Title XIX			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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	4,166,316	119,449,771	0.034879	1,029	36	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,412,088	19,695,500	0.071696	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,266,056	124,302,346	0.018230	25,747	469	54.00
57.00	05700 CT SCAN	109,228	69,417,879	0.001573	9,207	14	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	159,081	5,317,889	0.029914	5,884	176	58.00
59.00	05900 CARDIAC CATHETERIZATION	578,661	28,756,318	0.020123	0	0	59.00
60.00	06000 LABORATORY	452,210	137,154,784	0.003297	52,803	174	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	286,306	42,713,077	0.006703	11,846	79	65.00
66.00	06600 PHYSICAL THERAPY	511,628	12,904,633	0.039647	162,962	6,461	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	3,972	4,030,393	0.000986	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	1,530	1,635,307	0.000936	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	248,565	7,077,354	0.035121	151,313	5,314	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	1,019	1,154,219	0.000883	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	20,479	4,355,272	0.004702	106,539	501	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	684	951,207	0.000719	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	725,710	129,727,953	0.005594	58,156	325	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	560,602	170,402,239	0.003290	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	506,090	246,484,551	0.002053	200,526	412	73.00
76.00	03020 RADIOLOGY	149,790	15,847,504	0.009452	496	5	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	383,663	955,448	0.401553	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	118,442	4,265,617	0.027767	0	0	90.50
91.00	09100 EMERGENCY	1,443,509	56,382,343	0.025602	1,230	31	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	34,980,979	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	14,105,629	1,237,962,583		787,738	13,997	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
	Title XIX	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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0	0	0	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
76.00	03020 CARDIOLOGY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0	0	0	0	0	90.50
91.00	09100 EMERGENCY	0	0	0	0	510,388	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	510,388	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
Title XIX		Subprovider - IRF	PPS

Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	
	4.00	5.00	6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	119,449,771	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	19,695,500	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	124,302,346	0.000000	54.00
57.00 05700 CT SCAN	0	0	0	69,417,879	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,317,889	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	28,756,318	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	137,154,784	0.000000	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	0	42,713,077	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	12,904,633	0.000000	66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0	0	4,030,393	0.000000	66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	1,635,307	0.000000	66.10
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	7,077,354	0.000000	67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	1,154,219	0.000000	67.10
68.00 06800 SPEECH PATHOLOGY	0	0	0	4,355,272	0.000000	68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0	0	951,207	0.000000	68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	129,727,953	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	170,402,239	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	246,484,551	0.000000	73.00
76.00 03020 CARDIOLOGY	0	0	0	15,847,504	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	955,448	0.000000	90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0	0	4,265,617	0.000000	90.50
91.00 09100 EMERGENCY	0	510,388	510,388	56,382,343	0.009052	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	34,980,979	0.000000	92.00
200.00 Total (lines 50 through 199)	0	510,388	510,388	1,237,962,583		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:36 am
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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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	1,029	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	25,747	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	9,207	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	5,884	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	52,803	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.000000	11,846	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	162,962	0	0	0	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.000000	0	0	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.000000	0	0	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0.000000	151,313	0	0	0	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.000000	0	0	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0.000000	106,539	0	0	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.000000	0	0	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	58,156	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	200,526	0	0	0	73.00
76.00	03020 CARDIOLOGY	0.000000	496	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0.000000	0	0	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.000000	0	0	0	0	90.50
91.00	09100 EMERGENCY	0.009052	1,230	11	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		787,738	11	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 8:36 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		83,883	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		83,883	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.		65,478	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		7,889	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)		23,916	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
<b>SWING BED ADJUSTMENT</b>				
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)		93,067,817	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)		93,067,817	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		185,120,476	28.00
29.00	Private room charges (excluding swing-bed charges)		161,657,819	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		23,462,657	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.502742	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		2,468.89	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		2,974.10	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)		93,067,817	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,109.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		26,534,802	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)		26,534,802	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 8:36 am		
Cost Center Description			Title XVIII		Hospital	PPS	
	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	16,055,706	9,208	1,743.67	2,261	3,942,438	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	12,338,402	8,919	1,383.38	0	0	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				42,762,128		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				73,239,368		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				3,358,161		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				1,996,049		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				5,354,210		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				67,885,158		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)				10,516		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,109.50		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				11,667,502		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/29/2019 8:36 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	10,633,452	93,067,817	0.114255	11,667,502	1,333,070	90.00
91.00	Nursing School cost	0	93,067,817	0.000000	11,667,502	0	91.00
92.00	Allied health cost	0	93,067,817	0.000000	11,667,502	0	92.00
93.00	All other Medical Education	0	93,067,817	0.000000	11,667,502	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058 Component CCN: 15-S058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 8:36 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,090	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,090	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,090	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)		993	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
<b>SWING BED ADJUSTMENT</b>				
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)		3,776,341	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)		3,776,341	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		3,776,341	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,222.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,213,565	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,213,565	41.00



COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1
					Component CCN: 15-S058		Date/Time Prepared: 5/29/2019 8:36 am
					Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00	
43.01 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	43.01	
44.00 CORONARY CARE UNIT						44.00	
45.00 BURN INTENSIVE CARE UNIT						45.00	
46.00 SURGICAL INTENSIVE CARE UNIT						46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00	
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					225,261	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,438,826	49.00	
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					183,228	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					12,651	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					195,879	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,242,947	53.00	
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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	
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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	
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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	
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 15-0058 Component CCN: 15-S058		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/29/2019 8:36 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	570,167	3,776,341	0.150984	0	0	90.00
91.00	Nursing School cost	0	3,776,341	0.000000	0	0	91.00
92.00	Allied health cost	0	3,776,341	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,776,341	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 8:36 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,907	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,907	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.		1,471	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,436	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,180	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
<b>SWING BED ADJUSTMENT</b>				
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)		3,440,710	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)		3,440,710	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		7,672,079	28.00
29.00	Private room charges (excluding swing-bed charges)		3,988,126	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,683,953	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.448472	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		2,711.17	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		2,565.43	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		145.74	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		65.36	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		96,145	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,344,565	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,183.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,396,636	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,396,636	41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1
					Component CCN: 15-T058		Date/Time Prepared: 5/29/2019 8:36 am
					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
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
43.01 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0		43.01
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						771,534	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						2,168,170	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						205,898	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						45,866	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						251,764	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						1,916,406	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 15-0058 Component CCN: 15-T058		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/29/2019 8:36 am	
		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	507,255	3,440,710	0.147427	0	0	90.00
91.00	Nursing School cost	0	3,440,710	0.000000	0	0	91.00
92.00	Allied health cost	0	3,440,710	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,440,710	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 8:36 am
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		83,883	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		83,883	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)		73,367	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)		2,501	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		4,201	15.00
16.00	Nursery days (title V or XIX only)		161	16.00
<b>SWING BED ADJUSTMENT</b>				
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)		93,067,817	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)		93,067,817	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		93,067,817	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,109.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,774,860	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)		2,774,860	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 8:36 am		
Cost Center Description			Title XIX		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	2,719,737	4,201	647.40	161	104,231	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	16,055,706	9,208	1,743.67	0	0	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	12,338,402	8,919	1,383.38	338	467,582	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					27,524,242	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					30,870,915	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)					368,672	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,053,287	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,421,959	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					28,448,956	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)					10,516	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,109.50	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					11,667,502	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/29/2019 8:36 am	
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	10,633,452	93,067,817	0.114255	11,667,502	1,333,070	90.00
91.00	Nursing School cost	0	93,067,817	0.000000	11,667,502	0	91.00
92.00	Allied health cost	0	93,067,817	0.000000	11,667,502	0	92.00
93.00	All other Medical Education	0	93,067,817	0.000000	11,667,502	0	93.00



COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058 Component CCN: 15-S058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 8:36 am
		Title XIX	Subprovider - IPF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,090 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,090 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,090 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)			65 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			4,201 15.00
16.00	Nursery days (title V or XIX only)			161 16.00
<b>SWING BED ADJUSTMENT</b>				
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)			3,776,341 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)			3,776,341 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)			3,776,341 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,222.12 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			79,438 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)			79,438 41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1
					Component CCN: 15-S058		Date/Time Prepared: 5/29/2019 8:36 am
					Title XIX	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.01
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
<b>Cost Center Description</b>							
						1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						88,669	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						168,107	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						11,994	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						4,383	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						16,377	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						151,730	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 15-0058 Component CCN: 15-S058		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/29/2019 8:36 am	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	570,167	3,776,341	0.150984	0	0	90.00
91.00	Nursing School cost	0	3,776,341	0.000000	0	0	91.00
92.00	Allied health cost	0	3,776,341	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,776,341	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 8:36 am
		Title XIX	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,907	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,907	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)		2,907	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)		11	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		4,201	15.00
16.00	Nursery days (title V or XIX only)		161	16.00
<b>SWING BED ADJUSTMENT</b>				
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)		3,440,710	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)		3,440,710	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		3,440,710	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,183.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		13,019	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)		13,019	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1	
				Component CCN: 15-T058		Date/Time Prepared: 5/29/2019 8:36 am	
				Title XIX	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
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
43.01 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0		43.01
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					238,420		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					251,439		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,919		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					14,008		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					15,927		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					235,512		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					0		70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					0		71.00
72.00 Program routine service cost (line 9 x line 71)					0		72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0		73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					0		74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0		75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0		76.00
77.00 Program capital-related costs (line 9 x line 76)					0		77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					0		78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0		79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0		80.00
81.00 Inpatient routine service cost per diem limitation					0		81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0		82.00
83.00 Reasonable inpatient routine service costs (see instructions)					0		83.00
84.00 Program inpatient ancillary services (see instructions)					0		84.00
85.00 Utilization review - physician compensation (see instructions)					0		85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					0		86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 15-0058 Component CCN: 15-T058		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/29/2019 8:36 am	
		Title XIX		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	507,255	3,440,710	0.147427	0	0	90.00
91.00	Nursing School cost	0	3,440,710	0.000000	0	0	91.00
92.00	Allied health cost	0	3,440,710	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,440,710	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		67,693,267		30.00
31.00	03100 INTENSIVE CARE UNIT		10,962,494		31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT		0		31.01
40.00	04000 SUBPROVIDER - I PF		0		40.00
41.00	04100 SUBPROVIDER - I RF		0		41.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.376277	20,437,219	7,690,055	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.552521	26,947	14,889	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.176994	12,337,795	2,183,716	54.00
57.00	05700 CT SCAN	0.036976	7,724,597	285,625	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.281534	1,468,405	413,406	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.115875	4,772,811	553,049	59.00
60.00	06000 LABORATORY	0.105986	27,799,529	2,946,361	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.180868	12,406,538	2,243,946	65.00
66.00	06600 PHYSICAL THERAPY	0.418729	2,117,613	886,706	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.411046	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.402449	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0.450809	1,119,458	504,662	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.363115	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0.367466	529,098	194,426	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.310224	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152280	24,822,388	3,779,953	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.211896	42,078,575	8,916,282	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.191929	41,613,444	7,986,827	73.00
76.00	03020 CARDIOLOGY	0.319785	3,079,544	984,792	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0.000000	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	2.144047	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.294349	0	0	90.50
91.00	09100 EMERGENCY	0.519790	6,112,917	3,177,433	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.333538	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		208,446,878	42,762,128	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		208,446,878		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0058 Component CCN: 15-S058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/29/2019 8:36 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT		0		31.01
40.00	04000 SUBPROVIDER - IPF		1,194,503		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.376277	157,725	59,348	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.552521	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.176994	7,833	1,386	54.00
57.00	05700 CT SCAN	0.036976	6,204	229	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.281534	5,739	1,616	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.115875	0	0	59.00
60.00	06000 LABORATORY	0.105986	123,093	13,046	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.180868	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.418729	105,134	44,023	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.411046	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.402449	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0.450809	34,712	15,648	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.363115	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0.367466	226	83	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.310224	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152280	2,176	331	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.211896	1,740	369	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.191929	458,887	88,074	73.00
76.00	03020 CARDIOLOGY	0.319785	150	48	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0.000000	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	2.144047	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.294349	0	0	90.50
91.00	09100 EMERGENCY	0.519790	2,039	1,060	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.333538	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		905,658	225,261	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		905,658		202.00



INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/29/2019 8:36 am
		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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT		0	31.01
40.00	04000 SUBPROVIDER - I PF		0	40.00
41.00	04100 SUBPROVIDER - IRF		3,151,003	41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.376277	3,283	1,235 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.552521	0	0 52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.176994	94,774	16,774 54.00
57.00	05700 CT SCAN	0.036976	33,839	1,251 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.281534	10,622	2,990 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.115875	0	0 59.00
60.00	06000 LABORATORY	0.105986	192,559	20,409 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500 RESPIRATORY THERAPY	0.180868	160,787	29,081 65.00
66.00	06600 PHYSICAL THERAPY	0.418729	527,105	220,714 66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.411046	0	0 66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.402449	0	0 66.10
67.00	06700 OCCUPATIONAL THERAPY	0.450809	503,569	227,013 67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.363115	0	0 67.10
68.00	06800 SPEECH PATHOLOGY	0.367466	325,614	119,652 68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.310224	0	0 68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152280	94,664	14,415 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.211896	11,440	2,424 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.191929	596,767	114,537 73.00
76.00	03020 CARDIOLOGY	0.319785	3,249	1,039 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000	0	0 90.00
90.10	09001 FAMILY PRACTICE CLINIC	0.000000	0	0 90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	2.144047	0	0 90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.294349	0	0 90.50
91.00	09100 EMERGENCY	0.519790	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.333538	0	0 92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,558,272	771,534 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net charges (line 200 minus line 201)		2,558,272	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/29/2019 8:36 am
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		38,862,766	30.00
31.00	03100	INTENSIVE CARE UNIT		12,057,010	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		17,246,154	31.01
40.00	04000	SUBPROVIDER - I PF		0	40.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
43.00	04300	NURSERY		2,463,855	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.376277	19,880,836	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.552521	9,945,694	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176994	7,923,242	54.00
57.00	05700	CT SCAN	0.036976	4,121,914	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.281534	835,083	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.115875	1,881,745	59.00
60.00	06000	LABORATORY	0.105986	20,706,816	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.180868	11,147,461	65.00
66.00	06600	PHYSICAL THERAPY	0.418729	931,446	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.411046	679	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.402449	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0.450809	690,072	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.363115	499	67.10
68.00	06800	SPEECH PATHOLOGY	0.367466	308,518	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.310224	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152280	343,946	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.211896	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.191929	24,404,432	73.00
76.00	03020	CARDIOLOGY	0.319785	1,187,310	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	2.144047	16,448	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.294349	0	90.50
91.00	09100	EMERGENCY	0.519790	4,546,775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.333538	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		108,872,916	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)		108,872,916	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0058 Component CCN: 15-S058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/29/2019 8:36 am	
		Title XIX	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT		0		31.01
40.00	04000 SUBPROVIDER - IPF		537,075		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.376277	23,950	9,012	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.552521	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.176994	3,696	654	54.00
57.00	05700 CT SCAN	0.036976	2,068	76	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.281534	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.115875	0	0	59.00
60.00	06000 LABORATORY	0.105986	72,750	7,710	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.180868	5,425	981	65.00
66.00	06600 PHYSICAL THERAPY	0.418729	37,027	15,504	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.411046	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.402449	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0.450809	25,497	11,494	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.363115	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0.367466	0	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.310224	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152280	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.211896	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.191929	190,138	36,493	73.00
76.00	03020 RADIOLOGY	0.319785	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0.000000	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	2.144047	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.294349	0	0	90.50
91.00	09100 EMERGENCY	0.519790	12,977	6,745	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.333538	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		373,528	88,669	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		373,528		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/29/2019 8:36 am	
		Title XIX	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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0	31.01
40.00	04000	SUBPROVIDER - I PF		0	40.00
41.00	04100	SUBPROVIDER - IRF		932,134	41.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.376277	1,029	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.552521	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176994	25,747	54.00
57.00	05700	CT SCAN	0.036976	9,207	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.281534	5,884	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.115875	0	59.00
60.00	06000	LABORATORY	0.105986	52,803	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.180868	11,846	65.00
66.00	06600	PHYSICAL THERAPY	0.418729	162,962	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.411046	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.402449	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0.450809	151,313	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.363115	0	67.10
68.00	06800	SPEECH PATHOLOGY	0.367466	106,539	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.310224	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152280	58,156	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.211896	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.191929	200,526	73.00
76.00	03020	CARDIOLOGY	0.319785	496	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	2.144047	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.294349	0	90.50
91.00	09100	EMERGENCY	0.519790	1,230	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.333538	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		787,738	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)		787,738	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 8:36 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
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)		36,704,564	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		11,448,236	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)		2,643,208	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		21,554,567	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		370.95	4.00
<b>Indirect Medical Education Adjustment</b>				
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)		16.76	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		3.00	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)		19.76	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		27.15	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)		19.76	12.00
13.00	Total allowable FTE count for the prior year.		19.76	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.		19.76	14.00
15.00	Sum of lines 12 through 14 divided by 3.		19.76	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		19.76	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.053269	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.054796	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.053269	21.00
22.00	IME payment adjustment (see instructions)		1,380,782	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		618,077	22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
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)		7.39	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)		1,380,782	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		618,077	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.12	30.00
31.00	Percentage of Medicaid patient days (see instructions)		33.82	31.00
32.00	Sum of lines 30 and 31		38.94	32.00
33.00	Allowable disproportionate share percentage (see instructions)		21.34	33.00
34.00	Disproportionate share adjustment (see instructions)		2,568,953	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 8:36 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>Uncompensated Care Adjustment</b>				
35.00	Total uncompensated care amount (see instructions)	6,766,695,163	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000810874	0.000656107	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	5,486,936	5,427,891	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	4,103,926	1,368,127	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	5,472,053		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)	60,217,796		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
				<b>Amount</b>
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		60,835,873	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		4,575,559	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).		871,697	52.00
53.00	Nursing and Allied Health Managed Care payment		27,539	53.00
54.00	Special add-on payments for new technologies		1,575	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		55,334	58.00
59.00	Total (sum of amounts on lines 49 through 58)		66,367,577	59.00
60.00	Primary payer payments		68,572	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		66,299,005	61.00
62.00	Deductibles billed to program beneficiaries		4,958,020	62.00
63.00	Coinurance billed to program beneficiaries		207,257	63.00
64.00	Allowable bad debts (see instructions)		540,007	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		351,005	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		157,553	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		61,484,733	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-41,122	70.93
70.94	HRR adjustment amount (see instructions)		-27,510	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 8:36 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)		Amount	
		0		1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			61,416,101	71.00
71.01	Sequestration adjustment (see instructions)			1,228,322	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			60,677,105	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)			-489,326	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
<b>HSP Bonus Payment Amount</b>					
100.00	HSP bonus amount (see instructions)			0	100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>					
101.00	HVBP adjustment factor (see instructions)		0.9991073745	0.9991073745	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>					
103.00	HRR adjustment factor (see instructions)		0.9995	0.9995	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
<b>Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment</b>					
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
<b>Cost Reimbursement</b>					
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
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>					
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
<b>Adjustment to Medicare Part A Inpatient Reimbursement</b>					
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
<b>Comparison of PPS versus Cost Reimbursement</b>					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 8:36 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		97	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		32,517,199	2.00
3.00	OPPS payments		29,456,220	3.00
4.00	Outlier payment (see instructions)		437,349	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		52,974	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		97	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		640	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)		640	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		640	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		543	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)		97	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)		29,946,543	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		128	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		5,158,757	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		24,787,755	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		369,749	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)		25,157,504	30.00
31.00	Primary payer payments		3,389	31.00
32.00	Subtotal (line 30 minus line 31)		25,154,115	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		818,593	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		532,085	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		539,123	36.00
37.00	Subtotal (see instructions)		25,686,200	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-240	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		25,686,440	40.00
40.01	Sequestration adjustment (see instructions)		513,729	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		25,216,825	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-44,114	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 15-0058

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/29/2019 8:36 am

		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		60,640,405		25,135,725	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	04/27/2018	36,700	04/27/2018	81,100	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		36,700		81,100	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)		60,677,105		25,216,825	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		489,326		44,114	6.02	
7.00	Total Medicare program liability (see instructions)		60,187,779		25,172,711	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: 15-0058  
Component CCN: 15-S058

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/29/2019 8:36 am

Title XVIII

Subprovider -  
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		851,248		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
<b>Program to Provider</b>						
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
<b>Provider to Program</b>						
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)		851,248		0	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
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
<b>Program to Provider</b>						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
<b>Provider to Program</b>						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		5,894		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		857,142		0	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: 15-0058  
Component CCN: 15-T058

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/29/2019 8:36 am

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					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		1,930,466		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,930,466		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		34,042		0	6.02
7.00	Total Medicare program liability (see instructions)		1,896,424		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: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/29/2019 8:36 am
		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: 15-0058 Component CCN: 15-S058	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part II Date/Time Prepared: 5/29/2019 8:36 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			887,232 1.00
2.00	Net IPF PPS Outlier Payments			36,718 2.00
3.00	Net IPF PPS ECT Payments			18,604 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			8.465753 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$ .			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			942,554 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			942,554 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			942,554 18.00
19.00	Deductibles			68,268 19.00
20.00	Subtotal (line 18 minus line 19)			874,286 20.00
21.00	Coinsurance			5,665 21.00
22.00	Subtotal (line 20 minus line 21)			868,621 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			9,224 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			5,996 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			2,680 25.00
26.00	Subtotal (sum of lines 22 and 24)			874,617 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			18 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			874,635 31.00
31.01	Sequestration adjustment (see instructions)			17,493 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			851,248 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			5,894 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			36,718 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: 15-0058 Component CCN: 15-T058	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part III Date/Time Prepared: 5/29/2019 8:36 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			1,789,252 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0508 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			112,723 3.00
4.00	Outlier Payments			38,643 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)			7.964384 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)			1,940,618 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)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			1,940,618 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			1,940,618 19.00
20.00	Deductibles			8,040 20.00
21.00	Subtotal (line 19 minus line 20)			1,932,578 21.00
22.00	Coinsurance			0 22.00
23.00	Subtotal (line 21 minus line 22)			1,932,578 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			3,922 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			2,549 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,316 26.00
27.00	Subtotal (sum of lines 23 and 25)			1,935,127 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)			1,935,127 32.00
32.01	Sequestration adjustment (see instructions)			38,703 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			1,930,466 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)			-34,042 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			38,643 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0058		Period: From 01/01/2018 To 12/31/2018		Worksheet E-4	
		Title XVIII		Hospital		Date/Time Prepared: 5/29/2019 8:36 am	
				PPS			
				1.00			
<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>							
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					24.76	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					3.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					27.76	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					27.15	6.00
7.00	Enter the lesser of line 5 or line 6					27.15	7.00
		Primary Care	Other	Total			
		1.00	2.00	3.00			
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	27.15	0.00	27.15		8.00	
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	27.15	0.00	27.15		9.00	
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00			10.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00			10.01	
11.00	Total weighted FTE count	27.15	0.00	27.15		11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	26.50	0.00	26.50		12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	26.63	0.00	26.63		13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	26.76	0.00	26.76		14.00	
15.00	Adjustment for residents in initial years of new programs	0.00	0.00	0.00		15.00	
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00	0.00		15.01	
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00	0.00		16.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00	0.00		16.01	
17.00	Adjusted rolling average FTE count	26.76	0.00	26.76		17.00	
18.00	Per resident amount	119,314.00	0.00	119,314.00		18.00	
19.00	Approved amount for resident costs	3,192,843	0	3,192,843		19.00	
				1.00			
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00		20.00	
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00		21.00	
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00		22.00	
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00		23.00	
24.00	Multiply line 22 time line 23			0		24.00	
25.00	Total direct GME amount (sum of lines 19 and 24)			3,192,843		25.00	
		Inpatient Part A	Managed care				
		1.00	2.00	3.00			
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>							
26.00	Inpatient Days (see instructions)	28,350	11,462	39,812		26.00	
27.00	Total Inpatient Days (see instructions)	98,226	98,226	196,452		27.00	
28.00	Ratio of inpatient days to total inpatient days	0.288620	0.116690	0.405310		28.00	
29.00	Program direct GME amount	921,518	372,573	1,294,091		29.00	
30.00	Reduction for direct GME payments for Medicare Advantage		52,645	52,645		30.00	
31.00	Net Program direct GME amount			1,241,446		31.00	

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet E-4 Date/Time Prepared: 5/29/2019 8:36 am
		Title XVIII	Hospital	PPS
				1.00
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>				
<b>Part A Reasonable Cost</b>				
37.00	Reasonable cost (see instructions)		76,846,364	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		68,572	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		76,777,792	41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)		32,570,270	42.00
43.00	Primary payer payments (see instructions)		3,389	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		32,566,881	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		109,344,673	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.702163	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.297837	47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)		1,241,446	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		871,697	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		369,749	50.00



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

Provider CCN: 15-0058

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

Worksheet G

Date/Time Prepared:  
5/29/2019 8:36 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	-3,694,000	0	0	0	1.00
2.00	Temporary investments	12,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	125,865,763	0	0	0	4.00
5.00	Other receivable	48,580,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-28,808,763	0	0	0	6.00
7.00	Inventory	17,814,000	0	0	0	7.00
8.00	Prepaid expenses	1,774,000	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	5,758,000	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	161,543,000	5,758,000	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	21,501,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	504,886,000	0	0	0	15.00
16.00	Accumulated depreciation	-460,418,000	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	294,503,000	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	360,472,000	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	11,184,000	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,184,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	533,199,000	5,758,000	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	43,776,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,179,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,469,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	54,424,000	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	152,350,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	14,051,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	166,401,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	220,825,000	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	312,374,000	0	0	0	52.00
53.00	Specific purpose fund	0	5,758,000	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	312,374,000	5,758,000	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	533,199,000	5,758,000	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0058

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

Worksheet G-1

Date/Time Prepared:  
5/29/2019 8:36 am

		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		290,987,000		6,814,000	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		120,105,000			2.00
3.00	Total (sum of line 1 and line 2)		411,092,000		6,814,000	3.00
4.00	CAPITAL CONTRIBUTIONS	0		-1,056,000		4.00
5.00	NET ASSETS RELEASED FROM RESTRICTION	1,155,000		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		1,155,000		-1,056,000	10.00
11.00	Subtotal (line 3 plus line 10)		412,247,000		5,758,000	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00	TRANSFER TO BEACON HEALTH SYSTEM	99,873,000		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		99,873,000		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		312,374,000		5,758,000	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	CAPITAL CONTRIBUTIONS		0			4.00
5.00	NET ASSETS RELEASED FROM RESTRICTION		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	TRANSFER TO BEACON HEALTH SYSTEM		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: 15-0058

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/29/2019 8:36 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	237,361,640		237,361,640	1.00
2.00	SUBPROVIDER - IPF	3,858,674		3,858,674	2.00
3.00	SUBPROVIDER - IRF	7,990,356		7,990,356	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	249,210,670		249,210,670	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	47,961,569		47,961,569	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	28,892,740		28,892,740	11.01
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	76,854,309		76,854,309	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	326,064,979		326,064,979	17.00
18.00	Ancillary services	630,298,638	0	630,298,638	18.00
19.00	Outpatient services	0	618,353,495	618,353,495	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	956,363,617	618,353,495	1,574,717,112	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		447,626,907		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		447,626,907		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0058

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

Worksheet G-3

Date/Time Prepared:  
5/29/2019 8:36 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,574,717,112	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,030,878,899	2.00
3.00	Net patient revenues (line 1 minus line 2)	543,838,213	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	447,626,907	4.00
5.00	Net income from service to patients (line 3 minus line 4)	96,211,306	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	122,439	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	1,583,399	11.00
12.00	Parking lot receipts	324,563	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,617,322	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	2,458,789	23.00
24.00	MISC OTHER REVENUE	16,158,929	24.00
25.00	Total other income (sum of lines 6-24)	22,265,441	25.00
26.00	Total (line 5 plus line 25)	118,476,747	26.00
27.00	UNREALIZED LOSS ON SWAP	-1,628,253	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-1,628,253	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	120,105,000	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0058	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/29/2019 8:36 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		3,892,956	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		277,735	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)		256.54	3.00
4.00	Number of interns & residents (see instructions)		19.76	4.00
5.00	Indirect medical education percentage (see instructions)		2.19	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)		85,256	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		5.12	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		33.82	8.00
9.00	Sum of lines 7 and 8		38.94	9.00
10.00	Allowable disproportionate share percentage (see instructions)		8.21	10.00
11.00	Disproportionate share adjustment (see instructions)		319,612	11.00
12.00	Total prospective capital payments (see instructions)		4,575,559	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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