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: 15-0035	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/21/2019 3:36 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/21/2019 Time: 3:36 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PORTER MEMORIAL HOSPITAL (15-0035) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	312,035	92,078	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	27,173	-99		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	339,208	91,979	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: 15-0035	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/21/2019 3:36 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 85 EAST US HIGHWAY 6	PO Box:			1.00
2.00	City: VALPARAISO	State: IN	Zip Code: 46383	County: PORTER	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PORTER MEMORIAL HOSPITAL	150035	23844	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	PORTER REHAB UNIT	15T035	23844	5	01/01/2009	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	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)	4		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	856	539	10	68	7,991	254	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/21/2019 3:36 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	137		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/21/2019 3:36 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/21/2019 3:36 pm

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/21/2019 3:36 pm

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	330,000	426,406	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/21/2019 3:36 pm

		1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS INC	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 52280		141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:			142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067		143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2018	03/31/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/21/2019 3:36 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	Y	Y	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.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/10/2019	Y	04/10/2019	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/21/2019 3:36 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	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.	Y	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VICTORIA	ROMANKO	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-925-4333	VICTORIA_ROMANKO@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/21/2019 3:36 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/21/2019 3:36 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	192	70,080	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)		192	70,080	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	32	11,680	0.00	0	8.00
8.01	NEONATAL INTENSIVE CARE UNIT	31.01	14	5,110	0.00	0	8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		238	86,870	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	14	5,110		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)		252				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/21/2019 3:36 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	19,626	658	45,108			1.00
2.00	HMO and other (see instructions)	9,529	7,546				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	378	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	19,626	658	45,108			7.00
8.00	INTENSIVE CARE UNIT	2,900	49	6,088			8.00
8.01	NEONATAL INTENSIVE CARE UNIT	0	45	2,983			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		1,166	2,632			13.00
14.00	Total (see instructions)	22,526	1,918	56,811	0.00	1,415.18	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	2,017	137	3,077	0.00	14.97	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)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1,430.15	27.00
28.00	Observation Bed Days		0	4,886			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	254	598			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: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/21/2019 3:36 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	4,193	1,442	11,351	1.00
2.00	HMO and other (see instructions)			1,427	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
8.01	NEONATAL INTENSIVE CARE UNIT						8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	4,193	1,442	11,351	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	187	9	279	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/21/2019 3:36 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	85,901,563	0	85,901,563	2,974,706.00	28.88	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		139,238	0	139,238	800.00	174.05	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,085,967	0	1,085,967	37,965.00	28.60	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,180,497	0	3,180,497	39,507.00	80.50	11.00
12.00	Contract labor: Top level management and other management and administrative services		219,999	0	219,999	11,013.00	19.98	12.00
13.00	Contract labor: Physician-Part A - Administrative		556,034	0	556,034	4,494.00	123.73	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		8,820,752	0	8,820,752	289,648.00	30.45	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		23,401,236	0	23,401,236			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		308,251	0	308,251			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		12,159	0	12,159			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,710,309	0	1,710,309			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	328,815	0	328,815	8,825.00	37.26	26.00
27.00	Administrative & General	5.00	9,579,528	-149,023	9,430,505	378,126.00	24.94	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/21/2019 3:36 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		738,609	0	738,609	33,085.00	22.32	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,882,948	0	1,882,948	64,418.00	29.23	30.00
31.00	Laundry & Linen Service	8.00	130,858	0	130,858	8,689.00	15.06	31.00
32.00	Housekeeping	9.00	1,552,246	0	1,552,246	127,732.00	12.15	32.00
33.00	Housekeeping under contract (see instructions)		273,709	0	273,709	9,966.00	27.46	33.00
34.00	Dietary	10.00	1,931,825	-1,083,505	848,320	57,152.00	14.84	34.00
35.00	Dietary under contract (see instructions)		746,329	0	746,329	13,701.00	54.47	35.00
36.00	Cafeteria	11.00	0	1,083,505	1,083,505	72,996.00	14.84	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,117,722	149,023	2,266,745	52,245.00	43.39	38.00
39.00	Central Services and Supply	14.00	853,700	0	853,700	54,602.00	15.63	39.00
40.00	Pharmacy	15.00	2,788,007	0	2,788,007	59,040.00	47.22	40.00
41.00	Medical Records & Medical Records Library	16.00	619,534	0	619,534	31,795.00	19.49	41.00
42.00	Social Service	17.00	1,324,362	0	1,324,362	37,039.00	35.76	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 5/21/2019 3:36 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		87,660,210	0	87,660,210	3,031,458.00	28.92	1.00
2.00	Excluded area salaries (see instructions)		1,085,967	0	1,085,967	37,965.00	28.60	2.00
3.00	Subtotal salaries (line 1 minus line 2)		86,574,243	0	86,574,243	2,993,493.00	28.92	3.00
4.00	Subtotal other wages & related costs (see inst.)		12,777,282	0	12,777,282	344,662.00	37.07	4.00
5.00	Subtotal wage-related costs (see inst.)		25,123,704	0	25,123,704	0.00	29.02	5.00
6.00	Total (sum of lines 3 thru 5)		124,475,229	0	124,475,229	3,338,155.00	37.29	6.00
7.00	Total overhead cost (see instructions)		24,868,192	0	24,868,192	1,009,411.00	24.64	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 5/21/2019 3:36 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,717,418	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	14,035,075	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	297,509	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	64,606	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	288	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	212,407	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,105,007	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	4,913,092	17.00
18.00	Medicare Taxes - Employers Portion Only	1,149,030	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	227,215	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	23,721,647	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 5/21/2019 3:36 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	3,180,497	23,721,647	1.00
2.00	Hospital	3,180,497	23,721,647	2.00
3.00	Subprovider - IPF			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	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/21/2019 3:36 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.121758	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	33,765,782	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	225,281,433	6.00
7.00	Medicaid cost (line 1 times line 6)	27,429,817	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)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	1,563	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	190	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	190	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	190	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	14,271,296	82,958	14,354,254	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,737,644	82,958	1,820,602	21.00
22.00	Payments received from patients for amounts previously written off as charity care	88,664	0	88,664	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,648,980	82,958	1,731,938	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	14,736,260	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	796,604	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,225,546	27.01
28.00	Non-Medicare bad debt expense (see instructions)	13,510,714	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,073,980	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,805,918	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,806,108	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/21/2019 3:36 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,491,111	4,491,111	3,178,990	7,670,101	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		9,351,817	9,351,817	2,082,237	11,434,054	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	328,815	483,130	811,945	17,538,219	18,350,164	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,579,528	73,673,432	83,252,960	-21,961,057	61,291,903	5.00
7.00	00700	OPERATION OF PLANT	1,882,948	6,647,497	8,530,445	3,523,385	12,053,830	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	130,858	1,219,781	1,350,639	0	1,350,639	8.00
9.00	00900	HOUSEKEEPING	1,552,246	1,601,395	3,153,641	-7,780	3,145,861	9.00
10.00	01000	DIETARY	1,931,825	1,071,321	3,003,146	-1,725,652	1,277,494	10.00
11.00	01100	CAFETERIA	0	0	0	1,631,660	1,631,660	11.00
13.00	01300	NURSING ADMINISTRATION	2,117,722	367,723	2,485,445	149,023	2,634,468	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	853,700	23,906,480	24,760,180	-23,316,476	1,443,704	14.00
15.00	01500	PHARMACY	2,788,007	25,328,963	28,116,970	-24,988,034	3,128,936	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	619,534	1,384,440	2,003,974	0	2,003,974	16.00
17.00	01700	SOCIAL SERVICE	1,324,362	201,691	1,526,053	0	1,526,053	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,380,890	5,125,804	21,506,694	-554,609	20,952,085	30.00
31.00	03100	INTENSIVE CARE UNIT	4,814,476	3,755,695	8,570,171	-74,624	8,495,547	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	1,584,989	968,914	2,553,903	-6,725	2,547,178	31.01
41.00	04100	SUBPROVIDER - IRF	1,002,812	302,306	1,305,118	-4,633	1,300,485	41.00
43.00	04300	NURSERY	123,629	60,924	184,553	442,337	626,890	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,420,853	6,723,962	13,144,815	1,890,836	15,035,651	50.00
51.00	05100	RECOVERY ROOM	2,141,739	364,640	2,506,379	-2,506,379	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,824,131	633,738	2,457,869	32,703	2,490,572	52.00
53.00	05300	ANESTHESIOLOGY	0	2,269,406	2,269,406	0	2,269,406	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,494,474	1,898,591	7,393,065	1,736,132	9,129,197	54.00
54.01	05401	ULTRASOUND	447,300	251,009	698,309	-698,309	0	54.01
56.00	05600	RADIOISOTOPE	375,974	613,172	989,146	-989,146	0	56.00
57.00	05700	CT SCAN	576,625	208,019	784,644	-784,644	0	57.00
58.00	05800	MRI	226,214	206,788	433,002	-433,002	0	58.00
60.00	06000	LABORATORY	4,680,125	6,442,756	11,122,881	-520,619	10,602,262	60.00
65.00	06500	RESPIRATORY THERAPY	1,780,581	581,308	2,361,889	-119,819	2,242,070	65.00
66.00	06600	PHYSICAL THERAPY	1,977,651	183,933	2,161,584	-3,767	2,157,817	66.00
67.00	06700	OCCUPATIONAL THERAPY	629,408	46,491	675,899	0	675,899	67.00
68.00	06800	SPEECH PATHOLOGY	614,175	48,544	662,719	-1,760	660,959	68.00
69.00	06900	ELECTROCARDIOLOGY	3,887,168	5,326,276	9,213,444	-211,502	9,001,942	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	393,777	393,777	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,144,124	22,144,124	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,465	242,937	367,402	24,590,965	24,958,367	73.00
74.00	07400	RENAL DIALYSIS	0	633,683	633,683	0	633,683	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	313,115	51,069	364,184	-364,184	0	76.01
76.03	03951	WOUND CARE	797,202	748,913	1,546,115	-106	1,546,009	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,490,867	9,626,943	16,117,810	-61,561	16,056,249	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,818,408	197,044,602	282,863,010	0	282,863,010	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	83,155	74,526	157,681	0	157,681	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,663	4,663	0	4,663	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	85,901,563	197,123,791	283,025,354	0	283,025,354	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/21/2019 3:36 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,483,113	9,153,214		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,137,578	10,296,476		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,308	18,344,856		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,641,926	51,649,977		5.00
7.00	00700	OPERATION OF PLANT	0	12,053,830		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,350,639		8.00
9.00	00900	HOUSEKEEPING	0	3,145,861		9.00
10.00	01000	DIETARY	0	1,277,494		10.00
11.00	01100	CAFETERIA	0	1,631,660		11.00
13.00	01300	NURSING ADMINISTRATION	-42,058	2,592,410		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,443,704		14.00
15.00	01500	PHARMACY	0	3,128,936		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-227	2,003,747		16.00
17.00	01700	SOCIAL SERVICE	0	1,526,053		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,410,474	19,541,611		30.00
31.00	03100	INTENSIVE CARE UNIT	-2,579,383	5,916,164		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	-725,400	1,821,778		31.01
41.00	04100	SUBPROVIDER - IRF	0	1,300,485		41.00
43.00	04300	NURSERY	0	626,890		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-762,364	14,273,287		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-201,250	2,289,322		52.00
53.00	05300	ANESTHESIOLOGY	-2,069,997	199,409		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-78,119	9,051,078		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	10,602,262		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,242,070		65.00
66.00	06600	PHYSICAL THERAPY	0	2,157,817		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	675,899		67.00
68.00	06800	SPEECH PATHOLOGY	0	660,959		68.00
69.00	06900	ELECTROCARDIOLOGY	-3,042,995	5,958,947		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	393,777		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,144,124		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,958,367		73.00
74.00	07400	RENAL DIALYSIS	0	633,683		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	1,546,009		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-7,722,658	8,333,591		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-27,936,624	254,926,386		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	157,681		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,663		192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0		192.01
194.00	07950	NONREIMBURSABLE	0	0		194.00
194.01	07951	MARKETING	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0		194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0		194.03
194.04	07954	VACANT UNFINISHED AREA	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-27,936,624	255,088,730		200.00

RECLASSIFICATIONS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/21/2019 3:36 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	17,541,029		1.00
	0		0	17,541,029		
	C - RENTAL AND LEASE EXPENSES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	343,100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,970,724		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
	0		0	2,313,824		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	266,861		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,569,029		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	111,513		3.00
	0		0	2,947,403		
	E - REPAIRS AND MAINTENANCE COSTS					
1.00	OPERATION OF PLANT	7.00	0	3,525,436		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
	TOTALS		0	3,525,436		
	F - CHIEF NURSING OFFICER COST					
1.00	NURSING ADMINISTRATION	13.00	149,023	0		1.00
	0		149,023	0		
	G - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	393,777		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	22,144,124		2.00
3.00	OPERATING ROOM	50.00	0	749,544		3.00
	0		0	23,287,445		
	H - COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	24,590,965		1.00
	0		0	24,590,965		
	I - LABOR AND DELIVERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	0	80,525		1.00
2.00	NURSERY	43.00	380,274	62,310		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	180,276	0		3.00
	TOTALS		560,550	142,835		

RECLASSIFICATIONS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/21/2019 3:36 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	K - RECOVERY ROOM					
1.00	OPERATING ROOM	50.00	2,141,739	364,511		1.00
	0		2,141,739	364,511		
	L - OTHER RADIOLOGY COST					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	1,626,113	887,664		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
	0		1,626,113	887,664		
	M - DIETARY COSTS TO CAFETERIA					
1.00	CAFETERIA	11.00	1,083,505	548,155		1.00
	0		1,083,505	548,155		
	O - SLEEP LAB COSTS TO EKG					
1.00	ELECTROCARDIOLOGY	69.00	313,115	48,225		1.00
	0		313,115	48,225		
500.00	Grand Total: Increases		5,874,045	76,197,492		500.00

RECLASSIFICATIONS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/21/2019 3:36 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,541,029	0		1.00
	0		0	17,541,029			
	C - RENTAL AND LEASE EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	954,736	10		1.00
2.00	OPERATION OF PLANT	7.00	0	2,051	10		2.00
3.00	DIETARY	10.00	0	11,302	0		3.00
4.00	SLEEP LAB	76.01	0	2,844	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	30,720	0		5.00
6.00	PHARMACY	15.00	0	237,838	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	73,789	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	54,877	0		8.00
9.00	SUBPROVIDER - IRF	41.00	0	4,633	0		9.00
10.00	OPERATING ROOM	50.00	0	461,782	0		10.00
11.00	LABORATORY	60.00	0	251,381	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	112,579	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	34,322	0		13.00
14.00	MRI	58.00	0	850	0		14.00
15.00	EMERGENCY	91.00	0	41,769	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	37,040	0		16.00
17.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,205	0		17.00
18.00	WOUND CARE	76.03	0	106	0		18.00
	0		0	2,313,824			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,947,403	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	2,947,403			
	E - REPAIRS AND MAINTENANCE COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,810	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	368,866	0		2.00
3.00	HOUSEKEEPING	9.00	0	7,780	0		3.00
4.00	DIETARY	10.00	0	82,690	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	57,230	0		5.00
6.00	PHARMACY	15.00	0	110,062	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	795	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	19,747	0		8.00
9.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	6,725	0		9.00
10.00	NURSERY	43.00	0	247	0		10.00
11.00	OPERATING ROOM	50.00	0	903,176	0		11.00
12.00	RECOVERY ROOM	51.00	0	129	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	3,533	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	740,605	0		14.00
15.00	ULTRASOUND	54.01	0	34,153	0		15.00
16.00	RADIOISOTOPE	56.00	0	51,715	0		16.00
17.00	CT SCAN	57.00	0	133,047	0		17.00
18.00	MRI	58.00	0	171,559	0		18.00
19.00	LABORATORY	60.00	0	269,238	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	7,240	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	3,767	0		21.00
22.00	SPEECH PATHOLOGY	68.00	0	1,760	0		22.00
23.00	ELECTROCARDIOLOGY	69.00	0	528,770	0		23.00
24.00	EMERGENCY	91.00	0	19,792	0		24.00
	TOTALS		0	3,525,436			
	F - CHIEF NURSING OFFICER COST						
1.00	ADMINISTRATIVE & GENERAL	5.00	149,023	0	0		1.00
	0		149,023	0			
	G - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	23,228,526	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	9,750	0		2.00
3.00	PHARMACY	15.00	0	49,169	0		3.00
	0		0	23,287,445			
	H - COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	24,590,965	0		1.00
	0		0	24,590,965			
	I - LABOR AND DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	560,550	0	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	142,835	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		560,550	142,835			
	K - RECOVERY ROOM						
1.00	RECOVERY ROOM	51.00	2,141,739	364,511	0		1.00
	0		2,141,739	364,511			

RECLASSIFICATIONS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/21/2019 3:36 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	L - OTHER RADIOLOGY COST						
1.00	ULTRASOUND	54.01	447,300	216,856	0		1.00
2.00	RADIOISOTOPE	56.00	375,974	561,457	0		2.00
3.00	CT SCAN	57.00	576,625	74,972	0		3.00
4.00	MRI	58.00	226,214	34,379	0		4.00
	0		1,626,113	887,664			
	M - DIETARY COSTS TO CAFETERIA						
1.00	DIETARY	10.00	1,083,505	548,155	0		1.00
	0		1,083,505	548,155			
	O - SLEEP LAB COSTS TO EKG						
1.00	SLEEP LAB	76.01	313,115	48,225	0		1.00
	0		313,115	48,225			
500.00	Grand Total: Decreases		5,874,045	76,197,492			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/21/2019 3:36 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,949,373	0	0	0	0	1.00
2.00	Land Improvements	3,504,286	2,040	0	2,040	0	2.00
3.00	Buildings and Fixtures	166,692,824	0	0	0	0	3.00
4.00	Building Improvements	5,544,343	1,747,356	0	1,747,356	9,516	4.00
5.00	Fixed Equipment	6,738,682	157,209	0	157,209	72,868	5.00
6.00	Movable Equipment	70,146,842	1,776,856	0	1,776,856	3,588,347	6.00
7.00	HIT designated Assets	17,815,555	0	0	0	121,789	7.00
8.00	Subtotal (sum of lines 1-7)	273,391,905	3,683,461	0	3,683,461	3,792,520	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	273,391,905	3,683,461	0	3,683,461	3,792,520	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,949,373	0	1.00
2.00	Land Improvements	3,506,326	0	2.00
3.00	Buildings and Fixtures	166,692,824	0	3.00
4.00	Building Improvements	7,282,183	0	4.00
5.00	Fixed Equipment	6,823,023	0	5.00
6.00	Movable Equipment	68,335,351	0	6.00
7.00	HIT designated Assets	17,693,766	0	7.00
8.00	Subtotal (sum of lines 1-7)	273,282,846	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	273,282,846	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/21/2019 3:36 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,491,111	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,351,817	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	13,842,928	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	4,491,111		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,351,817		2.00
3.00	Total (sum of lines 1-2)	0	13,842,928		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/21/2019 3:36 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	180,430,706	0	180,430,706	0.660234	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	92,852,140	0	92,852,140	0.339766	0	2.00
3.00	Total (sum of lines 1-2)	273,282,846	0	273,282,846	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	5,245,126	343,100	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,214,239	1,970,724	2.00
3.00	Total (sum of lines 1-2)	0	0	0	13,459,365	2,313,824	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	729,098	266,861	2,569,029	0	9,153,214	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	111,513	0	0	10,296,476	2.00
3.00	Total (sum of lines 1-2)	729,098	378,374	2,569,029	0	19,449,690	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/21/2019 3:36 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-95,294	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-95,537	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-18,648,553			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-2,085,248			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-227	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	543,121	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,861,925	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TRAINING REVENUE	B	-42,058	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/21/2019 3:36 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC. NON PATIENT REVENUE	B	-28,723	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	NON-ALLOWABLE LEGAL FEES	A	-130,592	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PATIENT PHONES WAGE COSTS	A	-19,221	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PATIENT PHONES BENEFITS COSTS	A	-5,308	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	PATIENT TV DEPRECIATION	A	-5,436	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06	MARKETING	A	-1,122,301	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PHYSICIAN RECRUITING	A	-830,082	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-14,952	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	CHARITABLE CONTRIBUTIONS	A	-83,055	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	MEMBERSHIP DUES	A	-13,633	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MINORITY INTEREST	A	-3,311,528	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PATIENT PHONE DEPRECIATION	A	-447	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.12
33.14	PENALTIES	A	-8	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	GRANT INCOME	B	-13,883	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	SENIOR CIRCLE	A	-71,734	ADMINISTRATIVE & GENERAL	5.00	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-27,936,624				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: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/21/2019 3:36 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	128,791	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	802,813	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	7,444,275	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	Capital-Related Interest	729,098	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	82,103	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	22,954	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	PASI Operating Costs	1,208,784	1,617,150	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	Shared Service Center Alloca	3,800,883	2,610,132	4.04
4.08	5.00	ADMINISTRATIVE & GENERAL	Malpractice Costs (See Exhib	756,406	2,664,034	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	Interest Expense	0	2,517,632	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	Management Fees	0	4,013,746	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	401K Fees	0	5,164	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	Audit Fees	0	107,477	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	Corporate Overhead Allocatio	0	2,079,285	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	HIIM Allocation	0	1,076,374	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	Contract Management	0	123,924	4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	PASI Lien Unit Collection Fe	0	213,829	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	PPSI Fees	0	32,608	4.17
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,976,107	17,061,355	5.00

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/21/2019 3:36 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	128,791	9		1.00
2.00	802,813	9		2.00
3.00	7,444,275	0		3.00
4.00	729,098	11		4.00
4.01	82,103	9		4.01
4.02	22,954	9		4.02
4.03	-408,366	0		4.03
4.04	1,190,751	0		4.04
4.08	-1,907,628	0		4.08
4.09	-2,517,632	11		4.09
4.10	-4,013,746	0		4.10
4.11	-5,164	0		4.11
4.12	-107,477	0		4.12
4.13	-2,079,285	0		4.13
4.14	-1,076,374	0		4.14
4.15	-123,924	0		4.15
4.16	-213,829	0		4.16
4.17	-32,608	0		4.17
5.00	-2,085,248			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: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/21/2019 3:36 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,410,474	1,410,474	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	2,580,522	2,579,322	1,200	197,500	12	2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	725,400	725,400	0	0	0	3.00
4.00	50.00	OPERATING ROOM	762,364	762,364	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	2,069,997	2,069,997	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	78,119	78,119	0	0	0	6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	201,250	201,250	0	0	0	7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	55,913	55,913	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	3,042,995	3,042,995	0	0	0	9.00
10.00	91.00	EMERGENCY	7,722,658	7,722,658	0	0	0	10.00
200.00			18,649,692	18,648,492	1,200		12	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	1,139	57	0	0	0	2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			1,139	57	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	30.00	ADULTS & PEDIATRICS	0	0	0	1,410,474		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	1,139	61	2,579,383		2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	725,400		3.00
4.00	50.00	OPERATING ROOM	0	0	0	762,364		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	2,069,997		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	78,119		6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	201,250		7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	55,913		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	3,042,995		9.00
10.00	91.00	EMERGENCY	0	0	0	7,722,658		10.00
200.00			0	1,139	61	18,648,553		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/21/2019 3:36 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	9,153,214	9,153,214				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	10,296,476		10,296,476			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	18,344,856	30,771	35,286	18,410,913		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	51,649,977	382,395	438,494	2,028,964	54,499,830	5.00
7.00	00700	OPERATION OF PLANT	12,053,830	2,082,474	2,387,985	405,114	16,929,403	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,350,639	11,026	12,644	28,154	1,402,463	8.00
9.00	00900	HOUSEKEEPING	3,145,861	71,243	81,694	333,964	3,632,762	9.00
10.00	01000	DIETARY	1,277,494	224,904	257,899	182,515	1,942,812	10.00
11.00	01100	CAFETERIA	1,631,660	0	0	233,115	1,864,775	11.00
13.00	01300	NURSING ADMINISTRATION	2,592,410	39,779	45,615	487,688	3,165,492	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,443,704	156,256	179,180	183,673	1,962,813	14.00
15.00	01500	PHARMACY	3,128,936	85,717	98,292	599,837	3,912,782	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,003,747	29,526	33,857	133,292	2,200,422	16.00
17.00	01700	SOCIAL SERVICE	1,526,053	3,391	3,888	284,935	1,818,267	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,541,611	1,188,139	1,362,445	3,403,751	25,495,946	30.00
31.00	03100	INTENSIVE CARE UNIT	5,916,164	224,777	257,753	1,035,830	7,434,524	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	1,821,778	86,894	99,641	341,009	2,349,322	31.01
41.00	04100	SUBPROVIDER - IRF	1,300,485	152,912	175,345	215,754	1,844,496	41.00
43.00	04300	NURSERY	626,890	27,554	31,596	108,414	794,454	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,273,287	755,631	866,486	1,842,233	17,737,637	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,289,322	150,397	172,461	431,246	3,043,426	52.00
53.00	05300	ANESTHESIOLOGY	199,409	13,044	14,958	0	227,411	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,051,078	544,844	624,776	1,531,987	11,752,685	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	10,602,262	204,190	234,145	1,006,924	12,047,521	60.00
65.00	06500	RESPIRATORY THERAPY	2,242,070	36,746	42,137	383,090	2,704,043	65.00
66.00	06600	PHYSICAL THERAPY	2,157,817	158,529	181,785	425,490	2,923,621	66.00
67.00	06700	OCCUPATIONAL THERAPY	675,899	0	0	135,417	811,316	67.00
68.00	06800	SPEECH PATHOLOGY	660,959	0	0	132,139	793,098	68.00
69.00	06900	ELECTROCARDIOLOGY	5,958,947	347,298	398,248	903,687	7,608,180	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	393,777	0	0	0	393,777	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,144,124	0	0	0	22,144,124	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,958,367	0	0	26,779	24,985,146	73.00
74.00	07400	RENAL DIALYSIS	633,683	7,589	8,702	0	649,974	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	1,546,009	79,097	90,701	171,517	1,887,324	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,333,591	527,244	604,594	1,396,504	10,861,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	254,926,386	7,622,367	8,740,607	18,393,022	251,821,779	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	157,681	11,107	12,736	17,891	199,415	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,663	1,345,710	1,543,133	0	2,893,506	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	174,030	0	0	174,030	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
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)	255,088,730	9,153,214	10,296,476	18,410,913	255,088,730	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/21/2019 3:36 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	54,499,830					5.00
7.00	00700	OPERATION OF PLANT	4,599,702	21,529,105				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	381,048	35,656	1,819,167			8.00
9.00	00900	HOUSEKEEPING	987,018	230,383	0	4,850,163		9.00
10.00	01000	DIETARY	527,860	727,289	0	165,897	3,363,858	10.00
11.00	01100	CAFETERIA	506,658	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	860,061	128,637	0	29,342	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	533,294	505,298	8,551	115,260	0	14.00
15.00	01500	PHARMACY	1,063,099	277,190	11,982	63,228	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	597,852	95,480	0	21,779	0	16.00
17.00	01700	SOCIAL SERVICE	494,021	10,965	0	2,501	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,927,250	3,842,176	750,392	876,411	1,927,732	30.00
31.00	03100	INTENSIVE CARE UNIT	2,019,953	726,879	129,879	165,803	158,108	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	638,308	280,995	17,225	64,096	24,135	31.01
41.00	04100	SUBPROVIDER - IRF	501,148	494,482	28,809	112,793	131,780	41.00
43.00	04300	NURSERY	215,852	89,102	6,841	20,324	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,819,298	2,443,543	152,400	557,379	2,953	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	826,896	486,351	55,622	110,938	25,354	52.00
53.00	05300	ANESTHESIOLOGY	61,787	42,183	0	9,622	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,193,193	1,761,905	210,134	401,895	1,232	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	3,273,299	660,304	220	150,617	0	60.00
65.00	06500	RESPIRATORY THERAPY	734,686	118,828	0	27,105	0	65.00
66.00	06600	PHYSICAL THERAPY	794,345	512,646	10,632	116,936	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	220,434	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	215,484	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,067,135	1,123,084	114,949	256,178	25,272	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	106,989	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,016,536	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,788,439	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	176,597	24,541	0	5,598	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	512,784	255,782	7,073	58,345	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,951,176	1,704,990	314,458	388,913	42,676	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,612,202	16,578,689	1,819,167	3,720,960	2,339,242	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	54,181	35,917	0	8,193	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	786,163	4,351,726	0	992,640	523,746	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	47,284	562,773	0	128,370	500,870	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	54,499,830	21,529,105	1,819,167	4,850,163	3,363,858	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/21/2019 3:36 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,371,433					11.00
13.00	01300	NURSING ADMINISTRATION	54,905	4,238,437				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	57,374	0	3,182,590			14.00
15.00	01500	PHARMACY	62,030	215,268	9,440	5,615,019		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,419	0	621	0	2,949,573	16.00
17.00	01700	SOCIAL SERVICE	38,927	0	208	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	592,367	1,221,539	166,520	0	229,505	30.00
31.00	03100	INTENSIVE CARE UNIT	150,354	371,735	60,460	0	49,822	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	45,812	122,380	9,773	0	26,747	31.01
41.00	04100	SUBPROVIDER - IRF	32,720	77,429	6,405	0	12,863	41.00
43.00	04300	NURSERY	16,677	38,907	4,244	0	6,254	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	281,321	661,135	324,773	0	533,080	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	66,358	154,764	23,594	0	24,872	52.00
53.00	05300	ANESTHESIOLOGY	0	0	12,695	0	29,471	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	219,225	549,795	109,166	0	359,994	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	205,280	0	336,709	0	325,119	60.00
65.00	06500	RESPIRATORY THERAPY	60,325	0	27,805	0	69,403	65.00
66.00	06600	PHYSICAL THERAPY	59,669	0	2,180	0	32,023	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,251	0	1	0	16,056	67.00
68.00	06800	SPEECH PATHOLOGY	15,584	0	0	0	7,176	68.00
69.00	06900	ELECTROCARDIOLOGY	125,961	324,312	110,108	0	235,508	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,632	0	64,696	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,883,595	0	264,766	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,142	0	0	5,615,019	367,224	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	5,326	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	25,747	0	14,089	0	18,839	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	199,816	501,173	73,551	0	270,829	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,364,264	4,238,437	3,182,569	5,615,019	2,949,573	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,169	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	21	0	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,371,433	4,238,437	3,182,590	5,615,019	2,949,573	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/21/2019 3:36 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	2,364,889					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,781,249	43,811,087	0	43,811,087		30.00
31.00	03100	INTENSIVE CARE UNIT	240,406	11,507,923	0	11,507,923		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	117,794	3,696,587	0	3,696,587		31.01
41.00	04100	SUBPROVIDER - IRF	121,506	3,364,431	0	3,364,431		41.00
43.00	04300	NURSERY	103,934	1,296,589	0	1,296,589		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	27,513,519	0	27,513,519		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,818,175	0	4,818,175		52.00
53.00	05300	ANESTHESIOLOGY	0	383,169	0	383,169		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,559,224	0	18,559,224		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	16,999,069	0	16,999,069		60.00
65.00	06500	RESPIRATORY THERAPY	0	3,742,195	0	3,742,195		65.00
66.00	06600	PHYSICAL THERAPY	0	4,452,052	0	4,452,052		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,066,058	0	1,066,058		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,031,342	0	1,031,342		68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,990,687	0	11,990,687		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	572,094	0	572,094		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30,309,021	0	30,309,021		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	37,757,970	0	37,757,970		73.00
74.00	07400	RENAL DIALYSIS	0	862,036	0	862,036		74.00
76.00	03950	ANCILLARY	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0	0		76.01
76.03	03951	WOUND CARE	0	2,779,983	0	2,779,983		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	17,309,515	0	17,309,515		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,364,889	243,822,726	0	243,822,726		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	304,875	0	304,875		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,547,802	0	9,547,802		192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0		192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0		194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	1,413,327	0	1,413,327		194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,364,889	255,088,730	0	255,088,730		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/21/2019 3:36 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	30,771	35,286	66,057	66,057	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	382,395	438,494	820,889	7,280	5.00
7.00	00700	OPERATION OF PLANT	0	2,082,474	2,387,985	4,470,459	1,454	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,026	12,644	23,670	101	8.00
9.00	00900	HOUSEKEEPING	0	71,243	81,694	152,937	1,198	9.00
10.00	01000	DIETARY	0	224,904	257,899	482,803	655	10.00
11.00	01100	CAFETERIA	0	0	0	0	836	11.00
13.00	01300	NURSING ADMINISTRATION	0	39,779	45,615	85,394	1,750	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	156,256	179,180	335,436	659	14.00
15.00	01500	PHARMACY	0	85,717	98,292	184,009	2,152	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,526	33,857	63,383	478	16.00
17.00	01700	SOCIAL SERVICE	0	3,391	3,888	7,279	1,022	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,188,139	1,362,445	2,550,584	12,210	30.00
31.00	03100	INTENSIVE CARE UNIT	0	224,777	257,753	482,530	3,717	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	86,894	99,641	186,535	1,224	31.01
41.00	04100	SUBPROVIDER - IRF	0	152,912	175,345	328,257	774	41.00
43.00	04300	NURSERY	0	27,554	31,596	59,150	389	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	755,631	866,486	1,622,117	6,610	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	150,397	172,461	322,858	1,547	52.00
53.00	05300	ANESTHESIOLOGY	0	13,044	14,958	28,002	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	544,844	624,776	1,169,620	5,497	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	204,190	234,145	438,335	3,613	60.00
65.00	06500	RESPIRATORY THERAPY	0	36,746	42,137	78,883	1,375	65.00
66.00	06600	PHYSICAL THERAPY	0	158,529	181,785	340,314	1,527	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	486	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	474	68.00
69.00	06900	ELECTROCARDIOLOGY	0	347,298	398,248	745,546	3,243	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	96	73.00
74.00	07400	RENAL DIALYSIS	0	7,589	8,702	16,291	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	79,097	90,701	169,798	615	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	527,244	604,594	1,131,838	5,011	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,622,367	8,740,607	16,362,974	65,993	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,107	12,736	23,843	64	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,345,710	1,543,133	2,888,843	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	174,030	0	174,030	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
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	9,153,214	10,296,476	19,449,690	66,057	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/21/2019 3:36 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	828,169					5.00
7.00	00700	OPERATION OF PLANT	69,902	4,541,815				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,791	7,522	37,084			8.00
9.00	00900	HOUSEKEEPING	15,000	48,602	0	217,737		9.00
10.00	01000	DIETARY	8,022	153,430	0	7,448	652,358	10.00
11.00	01100	CAFETERIA	7,700	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	13,070	27,137	0	1,317	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,104	106,599	174	5,174	0	14.00
15.00	01500	PHARMACY	16,156	58,477	244	2,838	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,086	20,143	0	978	0	16.00
17.00	01700	SOCIAL SERVICE	7,508	2,313	0	112	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	105,208	810,552	15,298	39,344	373,848	30.00
31.00	03100	INTENSIVE CARE UNIT	30,697	153,344	2,648	7,443	30,662	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	9,700	59,279	351	2,877	4,680	31.01
41.00	04100	SUBPROVIDER - IRF	7,616	104,317	587	5,064	25,556	41.00
43.00	04300	NURSERY	3,280	18,797	139	912	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	73,239	515,494	3,107	25,022	573	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,566	102,601	1,134	4,980	4,917	52.00
53.00	05300	ANESTHESIOLOGY	939	8,899	0	432	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,527	371,694	4,284	18,042	239	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	49,744	139,299	4	6,762	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,165	25,068	0	1,217	0	65.00
66.00	06600	PHYSICAL THERAPY	12,072	108,149	217	5,250	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,350	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,275	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	31,414	236,928	2,343	11,501	4,901	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,626	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	91,433	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	103,164	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,684	5,177	0	251	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	7,793	53,960	144	2,619	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	44,849	359,687	6,410	17,459	8,276	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	814,680	3,497,468	37,084	167,042	453,652	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	823	7,577	0	368	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,947	918,047	0	44,564	101,571	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	719	118,723	0	5,763	97,135	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	828,169	4,541,815	37,084	217,737	652,358	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/21/2019 3:36 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	8,536					11.00
13.00	01300	NURSING ADMINISTRATION	198	128,866				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	207	0	456,353			14.00
15.00	01500	PHARMACY	223	6,546	1,354	271,999		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	120	0	89	0	94,277	16.00
17.00	01700	SOCIAL SERVICE	140	0	30	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,131	37,123	23,877	0	7,323	30.00
31.00	03100	INTENSIVE CARE UNIT	541	11,304	8,669	0	1,590	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	165	3,722	1,401	0	853	31.01
41.00	04100	SUBPROVIDER - IRF	118	2,355	918	0	410	41.00
43.00	04300	NURSERY	60	1,183	609	0	200	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,013	20,105	46,569	0	17,172	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	239	4,706	3,383	0	794	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,820	0	940	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	789	16,719	15,653	0	11,487	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	739	0	48,281	0	10,374	60.00
65.00	06500	RESPIRATORY THERAPY	217	0	3,987	0	2,214	65.00
66.00	06600	PHYSICAL THERAPY	215	0	313	0	1,022	66.00
67.00	06700	OCCUPATIONAL THERAPY	66	0	0	0	512	67.00
68.00	06800	SPEECH PATHOLOGY	56	0	0	0	229	68.00
69.00	06900	ELECTROCARDIOLOGY	453	9,862	15,788	0	7,515	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	951	0	2,064	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	270,092	0	8,448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8	0	0	271,999	11,717	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	170	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	93	0	2,020	0	601	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	719	15,241	10,546	0	8,642	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,510	128,866	456,350	271,999	94,277	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	26	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3	0	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,536	128,866	456,353	271,999	94,277	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/21/2019 3:36 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	18,404					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,861	3,991,359	0	3,991,359		30.00
31.00	03100	INTENSIVE CARE UNIT	1,871	735,016	0	735,016		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	917	271,704	0	271,704		31.01
41.00	04100	SUBPROVIDER - IRF	946	476,918	0	476,918		41.00
43.00	04300	NURSERY	809	85,528	0	85,528		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,331,021	0	2,331,021		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	459,725	0	459,725		52.00
53.00	05300	ANESTHESIOLOGY	0	41,032	0	41,032		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,662,551	0	1,662,551		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	697,151	0	697,151		60.00
65.00	06500	RESPIRATORY THERAPY	0	124,126	0	124,126		65.00
66.00	06600	PHYSICAL THERAPY	0	469,079	0	469,079		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,414	0	4,414		67.00
68.00	06800	SPEECH PATHOLOGY	0	4,034	0	4,034		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,069,494	0	1,069,494		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,641	0	4,641		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	369,973	0	369,973		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	386,984	0	386,984		73.00
74.00	07400	RENAL DIALYSIS	0	24,573	0	24,573		74.00
76.00	03950	ANCILLARY	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0	0		76.01
76.03	03951	WOUND CARE	0	237,643	0	237,643		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	1,608,678	0	1,608,678		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,404	15,055,644	0	15,055,644		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32,701	0	32,701		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,964,975	0	3,964,975		192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0		192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0		194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	396,370	0	396,370		194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	18,404	19,449,690	0	19,449,690		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/21/2019 3:36 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	793,617					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		778,528				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,668	2,668	85,572,748			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	33,155	33,155	9,430,505	-54,499,830	200,588,900	5.00
7.00	00700	OPERATION OF PLANT	180,558	180,558	1,882,948	0	16,929,403	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	956	956	130,858	0	1,402,463	8.00
9.00	00900	HOUSEKEEPING	6,177	6,177	1,552,246	0	3,632,762	9.00
10.00	01000	DIETARY	19,500	19,500	848,320	0	1,942,812	10.00
11.00	01100	CAFETERIA	0	0	1,083,505	0	1,864,775	11.00
13.00	01300	NURSING ADMINISTRATION	3,449	3,449	2,266,745	0	3,165,492	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,548	13,548	853,700	0	1,962,813	14.00
15.00	01500	PHARMACY	7,432	7,432	2,788,007	0	3,912,782	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,560	2,560	619,534	0	2,200,422	16.00
17.00	01700	SOCIAL SERVICE	294	294	1,324,362	0	1,818,267	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	103,016	103,016	15,820,340	0	25,495,946	30.00
31.00	03100	INTENSIVE CARE UNIT	19,489	19,489	4,814,476	0	7,434,524	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	7,534	7,534	1,584,989	0	2,349,322	31.01
41.00	04100	SUBPROVIDER - IRF	13,258	13,258	1,002,812	0	1,844,496	41.00
43.00	04300	NURSERY	2,389	2,389	503,903	0	794,454	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,516	65,516	8,562,592	0	17,737,637	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,040	13,040	2,004,407	0	3,043,426	52.00
53.00	05300	ANESTHESIOLOGY	1,131	1,131	0	0	227,411	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,240	47,240	7,120,587	0	11,752,685	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	17,704	17,704	4,680,125	0	12,047,521	60.00
65.00	06500	RESPIRATORY THERAPY	3,186	3,186	1,780,581	0	2,704,043	65.00
66.00	06600	PHYSICAL THERAPY	13,745	13,745	1,977,651	0	2,923,621	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	629,408	0	811,316	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	614,175	0	793,098	68.00
69.00	06900	ELECTROCARDIOLOGY	30,112	30,112	4,200,283	0	7,608,180	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	393,777	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	22,144,124	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	124,465	0	24,985,146	73.00
74.00	07400	RENAL DIALYSIS	658	658	0	0	649,974	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	6,858	6,858	797,202	0	1,887,324	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	45,714	45,714	6,490,867	0	10,861,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	660,887	660,887	85,489,593	-54,499,830	197,321,949	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	963	963	83,155	0	199,415	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	116,678	116,678	0	0	2,893,506	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	15,089	0	0	0	174,030	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
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)	9,153,214	10,296,476	18,410,913		54,499,830	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.533541	13.225569	0.215149		0.271699	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			66,057		828,169	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000772		0.004129	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/21/2019 3:36 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
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: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/21/2019 3:36 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	577,236					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	956	2,068,686				8.00
9.00	00900	HOUSEKEEPING	6,177	0	570,103			9.00
10.00	01000	DIETARY	19,500	0	19,500	248,372		10.00
11.00	01100	CAFETERIA	0	0	0	0	108,498	11.00
13.00	01300	NURSING ADMINISTRATION	3,449	0	3,449	0	2,512	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,548	9,724	13,548	0	2,625	14.00
15.00	01500	PHARMACY	7,432	13,626	7,432	0	2,838	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,560	0	2,560	0	1,529	16.00
17.00	01700	SOCIAL SERVICE	294	0	294	0	1,781	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	103,016	853,318	103,016	142,335	27,102	30.00
31.00	03100	INTENSIVE CARE UNIT	19,489	147,693	19,489	11,674	6,879	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	7,534	19,588	7,534	1,782	2,096	31.01
41.00	04100	SUBPROVIDER - IRF	13,258	32,761	13,258	9,730	1,497	41.00
43.00	04300	NURSERY	2,389	7,779	2,389	0	763	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,516	173,303	65,516	218	12,871	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,040	63,251	13,040	1,872	3,036	52.00
53.00	05300	ANESTHESIOLOGY	1,131	0	1,131	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,240	238,956	47,240	91	10,030	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	17,704	250	17,704	0	9,392	60.00
65.00	06500	RESPIRATORY THERAPY	3,186	0	3,186	0	2,760	65.00
66.00	06600	PHYSICAL THERAPY	13,745	12,090	13,745	0	2,730	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	835	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	713	68.00
69.00	06900	ELECTROCARDIOLOGY	30,112	130,715	30,112	1,866	5,763	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	98	73.00
74.00	07400	RENAL DIALYSIS	658	0	658	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	6,858	8,043	6,858	0	1,178	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	45,714	357,589	45,714	3,151	9,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	444,506	2,068,686	437,373	172,719	108,170	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	963	0	963	0	328	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	116,678	0	116,678	38,671	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	15,089	0	15,089	36,982	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
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)	21,529,105	1,819,167	4,850,163	3,363,858	2,371,433	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	37.296886	0.879383	8.507521	13.543628	21.856928	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,541,815	37,084	217,737	652,358	8,536	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.868212	0.017926	0.381926	2.626536	0.078674	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: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/21/2019 3:36 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	54,893,264					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	37,947,196				14.00
15.00	01500	PHARMACY	2,788,007	112,554	24,824,719			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,403	0	2,002,521,917		16.00
17.00	01700	SOCIAL SERVICE	0	2,481	0	0	59,888	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,820,340	1,985,473	0	155,808,211	45,108	30.00
31.00	03100	INTENSIVE CARE UNIT	4,814,476	720,891	0	33,823,290	6,088	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	1,584,989	116,526	0	18,158,105	2,983	31.01
41.00	04100	SUBPROVIDER - IRF	1,002,812	76,375	0	8,732,526	3,077	41.00
43.00	04300	NURSERY	503,903	50,599	0	4,245,677	2,632	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,562,592	3,872,379	0	361,996,097	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,004,408	281,320	0	16,885,519	0	52.00
53.00	05300	ANESTHESIOLOGY	0	151,362	0	20,007,600	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,120,587	1,301,624	0	244,395,311	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	4,014,697	0	220,719,203	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	331,532	0	47,116,797	0	65.00
66.00	06600	PHYSICAL THERAPY	0	25,996	0	21,739,931	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13	0	10,900,462	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,871,483	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,200,283	1,312,854	0	159,883,346	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	79,074	0	43,921,500	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,458,827	0	179,746,060	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	24,824,719	249,303,719	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,615,418	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	167,993	0	12,789,364	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,490,867	876,972	0	183,862,298	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,893,264	37,946,945	24,824,719	2,002,521,917	59,888	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	251	0	0	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
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)	4,238,437	3,182,590	5,615,019	2,949,573	2,364,889	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.077212	0.083869	0.226187	0.001473	39.488529	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	128,866	456,353	271,999	94,277	18,404	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002348	0.012026	0.010957	0.000047	0.307307	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/21/2019 3:36 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,811,087		43,811,087	0	43,811,087	30.00
31.00	03100	INTENSIVE CARE UNIT	11,507,923		11,507,923	61	11,507,984	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	3,696,587		3,696,587	0	3,696,587	31.01
41.00	04100	SUBPROVIDER - IRF	3,364,431		3,364,431	0	3,364,431	41.00
43.00	04300	NURSERY	1,296,589		1,296,589	0	1,296,589	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,513,519		27,513,519	0	27,513,519	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,818,175		4,818,175	0	4,818,175	52.00
53.00	05300	ANESTHESIOLOGY	383,169		383,169	0	383,169	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,559,224		18,559,224	0	18,559,224	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	16,999,069		16,999,069	0	16,999,069	60.00
65.00	06500	RESPIRATORY THERAPY	3,742,195	0	3,742,195	0	3,742,195	65.00
66.00	06600	PHYSICAL THERAPY	4,452,052	0	4,452,052	0	4,452,052	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,066,058	0	1,066,058	0	1,066,058	67.00
68.00	06800	SPEECH PATHOLOGY	1,031,342	0	1,031,342	0	1,031,342	68.00
69.00	06900	ELECTROCARDIOLOGY	11,990,687		11,990,687	0	11,990,687	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	572,094		572,094	0	572,094	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,309,021		30,309,021	0	30,309,021	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,757,970		37,757,970	0	37,757,970	73.00
74.00	07400	RENAL DIALYSIS	862,036		862,036	0	862,036	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	2,779,983		2,779,983	0	2,779,983	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	17,309,515		17,309,515	0	17,309,515	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,281,748		4,281,748		4,281,748	92.00
200.00		Subtotal (see instructions)	248,104,474	0	248,104,474	61	248,104,535	200.00
201.00		Less Observation Beds	4,281,748		4,281,748		4,281,748	201.00
202.00		Total (see instructions)	243,822,726	0	243,822,726	61	243,822,787	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/21/2019 3:36 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	141,082,578		141,082,578			30.00
31.00	03100	INTENSIVE CARE UNIT	33,823,290		33,823,290			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	18,158,105		18,158,105			31.01
41.00	04100	SUBPROVIDER - IRF	8,732,526		8,732,526			41.00
43.00	04300	NURSERY	4,245,677		4,245,677			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	155,687,514	206,308,583	361,996,097	0.076005	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,396,258	489,261	16,885,519	0.285344	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,930,206	11,077,394	20,007,600	0.019151	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,127,067	193,268,244	244,395,311	0.075939	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	86,451,433	134,267,770	220,719,203	0.077017	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	43,776,397	3,340,400	47,116,797	0.079424	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	13,488,761	8,251,170	21,739,931	0.204787	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,281,614	1,618,848	10,900,462	0.097799	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,873,852	1,997,631	4,871,483	0.211710	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	55,682,083	104,201,263	159,883,346	0.074996	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,486,553	22,434,947	43,921,500	0.013025	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,750,724	77,995,336	179,746,060	0.168621	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	67,418,874	181,884,845	249,303,719	0.151454	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,537,302	78,116	3,615,418	0.238433	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	421,760	12,367,604	12,789,364	0.217367	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	47,259,418	136,602,880	183,862,298	0.094144	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,956,480	9,769,153	14,725,633	0.290768	0.000000	92.00
200.00		Subtotal (see instructions)	896,568,472	1,105,953,445	2,002,521,917			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	896,568,472	1,105,953,445	2,002,521,917			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT			31.01
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.076005		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.285344		52.00
53.00	05300	ANESTHESIOLOGY	0.019151		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.075939		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.077017		60.00
65.00	06500	RESPIRATORY THERAPY	0.079424		65.00
66.00	06600	PHYSICAL THERAPY	0.204787		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.097799		67.00
68.00	06800	SPEECH PATHOLOGY	0.211710		68.00
69.00	06900	ELECTROCARDIOLOGY	0.074996		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.013025		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.168621		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151454		73.00
74.00	07400	RENAL DIALYSIS	0.238433		74.00
76.00	03950	ANCILLARY	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.03	03951	WOUND CARE	0.217367		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.094144		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290768		92.00
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: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/21/2019 3:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,811,087		43,811,087	0	43,811,087	30.00
31.00	03100	INTENSIVE CARE UNIT	11,507,923		11,507,923	61	11,507,984	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	3,696,587		3,696,587	0	3,696,587	31.01
41.00	04100	SUBPROVIDER - IRF	3,364,431		3,364,431	0	3,364,431	41.00
43.00	04300	NURSERY	1,296,589		1,296,589	0	1,296,589	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,513,519		27,513,519	0	27,513,519	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,818,175		4,818,175	0	4,818,175	52.00
53.00	05300	ANESTHESIOLOGY	383,169		383,169	0	383,169	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,559,224		18,559,224	0	18,559,224	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	16,999,069		16,999,069	0	16,999,069	60.00
65.00	06500	RESPIRATORY THERAPY	3,742,195	0	3,742,195	0	3,742,195	65.00
66.00	06600	PHYSICAL THERAPY	4,452,052	0	4,452,052	0	4,452,052	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,066,058	0	1,066,058	0	1,066,058	67.00
68.00	06800	SPEECH PATHOLOGY	1,031,342	0	1,031,342	0	1,031,342	68.00
69.00	06900	ELECTROCARDIOLOGY	11,990,687		11,990,687	0	11,990,687	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	572,094		572,094	0	572,094	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,309,021		30,309,021	0	30,309,021	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,757,970		37,757,970	0	37,757,970	73.00
74.00	07400	RENAL DIALYSIS	862,036		862,036	0	862,036	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	2,779,983		2,779,983	0	2,779,983	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	17,309,515		17,309,515	0	17,309,515	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,281,748		4,281,748		4,281,748	92.00
200.00		Subtotal (see instructions)	248,104,474	0	248,104,474	61	248,104,535	200.00
201.00		Less Observation Beds	4,281,748		4,281,748		4,281,748	201.00
202.00		Total (see instructions)	243,822,726	0	243,822,726	61	243,822,787	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/21/2019 3:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	141,082,578		141,082,578			30.00
31.00	03100	INTENSIVE CARE UNIT	33,823,290		33,823,290			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	18,158,105		18,158,105			31.01
41.00	04100	SUBPROVIDER - IRF	8,732,526		8,732,526			41.00
43.00	04300	NURSERY	4,245,677		4,245,677			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	155,687,514	206,308,583	361,996,097	0.076005	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,396,258	489,261	16,885,519	0.285344	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,930,206	11,077,394	20,007,600	0.019151	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,127,067	193,268,244	244,395,311	0.075939	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	86,451,433	134,267,770	220,719,203	0.077017	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	43,776,397	3,340,400	47,116,797	0.079424	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	13,488,761	8,251,170	21,739,931	0.204787	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,281,614	1,618,848	10,900,462	0.097799	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,873,852	1,997,631	4,871,483	0.211710	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	55,682,083	104,201,263	159,883,346	0.074996	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,486,553	22,434,947	43,921,500	0.013025	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,750,724	77,995,336	179,746,060	0.168621	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	67,418,874	181,884,845	249,303,719	0.151454	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,537,302	78,116	3,615,418	0.238433	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	421,760	12,367,604	12,789,364	0.217367	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	47,259,418	136,602,880	183,862,298	0.094144	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,956,480	9,769,153	14,725,633	0.290768	0.000000	92.00
200.00		Subtotal (see instructions)	896,568,472	1,105,953,445	2,002,521,917			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	896,568,472	1,105,953,445	2,002,521,917			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/21/2019 3:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT			31.01
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03950	ANCILLARY	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.03	03951	WOUND CARE	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I | Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,991,359	0	3,991,359	49,994	79.84	30.00
31.00	INTENSIVE CARE UNIT	735,016		735,016	6,088	120.73	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	271,704		271,704	2,983	91.08	31.01
41.00	SUBPROVIDER - IRF	476,918	0	476,918	3,077	154.99	41.00
43.00	NURSERY	85,528		85,528	2,632	32.50	43.00
200.00	Total (lines 30 through 199)	5,560,525		5,560,525	64,774		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	19,626	1,566,940				30.00
31.00	INTENSIVE CARE UNIT	2,900	350,117				31.00
31.01	NEONATAL INTENSIVE CARE UNIT	0	0				31.01
41.00	SUBPROVIDER - IRF	2,017	312,615				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	24,543	2,229,672				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,331,021	361,996,097	0.006439	59,756,939	384,775	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	459,725	16,885,519	0.027226	50,752	1,382	52.00
53.00	05300	ANESTHESIOLOGY	41,032	20,007,600	0.002051	2,829,293	5,803	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,662,551	244,395,311	0.006803	23,146,866	157,468	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	697,151	220,719,203	0.003159	36,388,678	114,952	60.00
65.00	06500	RESPIRATORY THERAPY	124,126	47,116,797	0.002634	22,178,681	58,419	65.00
66.00	06600	PHYSICAL THERAPY	469,079	21,739,931	0.021577	5,421,072	116,970	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,414	10,900,462	0.000405	3,464,335	1,403	67.00
68.00	06800	SPEECH PATHOLOGY	4,034	4,871,483	0.000828	1,210,524	1,002	68.00
69.00	06900	ELECTROCARDIOLOGY	1,069,494	159,883,346	0.006689	22,896,812	153,157	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,641	43,921,500	0.000106	8,715,008	924	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	369,973	179,746,060	0.002058	45,003,275	92,617	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	386,984	249,303,719	0.001552	27,713,832	43,012	73.00
74.00	07400	RENAL DIALYSIS	24,573	3,615,418	0.006797	1,635,626	11,117	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	WOUND CARE	237,643	12,789,364	0.018581	164,513	3,057	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1,608,678	183,862,298	0.008749	21,058,202	184,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	390,084	14,725,633	0.026490	2,177,467	57,681	92.00
200.00		Total (lines 50 through 199)	9,885,203	1,796,479,741		283,811,875	1,387,977	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
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	49,994	0.00	19,626	30.00
31.00	03100	INTENSIVE CARE UNIT		0	6,088	0.00	2,900	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0	2,983	0.00	0	31.01
41.00	04100	SUBPROVIDER - IRF	0	0	3,077	0.00	2,017	41.00
43.00	04300	NURSERY		0	2,632	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	64,774		24,543	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	31.01
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: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	361,996,097	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	16,885,519	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	20,007,600	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	244,395,311	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	220,719,203	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	47,116,797	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,739,931	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,900,462	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,871,483	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	159,883,346	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	43,921,500	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	179,746,060	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	249,303,719	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,615,418	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	12,789,364	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	183,862,298	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	14,725,633	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	1,796,479,741		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	59,756,939	0	62,399,934	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	50,752	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,829,293	0	2,747,708	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	23,146,866	0	55,440,302	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	36,388,678	0	16,354,652	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	22,178,681	0	1,052,100	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,421,072	0	308,498	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,464,335	0	168,788	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,210,524	0	14,262	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	22,896,812	0	38,702,727	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	8,715,008	0	7,060,063	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	45,003,275	0	33,401,964	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	27,713,832	0	67,853,346	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,635,626	0	62,090	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.000000	164,513	0	5,394,266	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	21,058,202	0	25,683,352	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,177,467	0	3,104,020	0	92.00
200.00		Total (lines 50 through 199)		283,811,875	0	319,748,072	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.076005	62,399,934	0	0	4,742,707	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.285344	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.019151	2,747,708	0	0	52,621	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.075939	55,440,302	0	0	4,210,081	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.077017	16,354,652	0	0	1,259,586	60.00
65.00	06500	RESPIRATORY THERAPY	0.079424	1,052,100	0	0	83,562	65.00
66.00	06600	PHYSICAL THERAPY	0.204787	308,498	0	0	63,176	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.097799	168,788	0	0	16,507	67.00
68.00	06800	SPEECH PATHOLOGY	0.211710	14,262	0	0	3,019	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074996	38,702,727	0	0	2,902,550	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.013025	7,060,063	0	0	91,957	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.168621	33,401,964	0	0	5,632,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151454	67,853,346	0	232,970	10,276,661	73.00
74.00	07400	RENAL DIALYSIS	0.238433	62,090	0	0	14,804	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.217367	5,394,266	0	0	1,172,535	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.094144	25,683,352	0	255	2,417,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290768	3,104,020	0	0	902,550	92.00
200.00		Subtotal (see instructions)		319,748,072	0	233,225	33,842,522	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		319,748,072	0	233,225	33,842,522	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	35,284		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	24		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	35,308		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	35,308		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,331,021	361,996,097	0.006439	7,877	51	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	459,725	16,885,519	0.027226	0	0	52.00
53.00	05300	ANESTHESIOLOGY	41,032	20,007,600	0.002051	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,662,551	244,395,311	0.006803	268,716	1,828	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	697,151	220,719,203	0.003159	923,623	2,918	60.00
65.00	06500	RESPIRATORY THERAPY	124,126	47,116,797	0.002634	3,009	8	65.00
66.00	06600	PHYSICAL THERAPY	469,079	21,739,931	0.021577	1,706,937	36,831	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,414	10,900,462	0.000405	1,823,984	739	67.00
68.00	06800	SPEECH PATHOLOGY	4,034	4,871,483	0.000828	392,693	325	68.00
69.00	06900	ELECTROCARDIOLOGY	1,069,494	159,883,346	0.006689	55,998	375	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,641	43,921,500	0.000106	20,070	2	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	369,973	179,746,060	0.002058	1,293	3	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	386,984	249,303,719	0.001552	1,188,614	1,845	73.00
74.00	07400	RENAL DIALYSIS	24,573	3,615,418	0.006797	176,286	1,198	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	WOUND CARE	237,643	12,789,364	0.018581	19,788	368	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1,608,678	183,862,298	0.008749	5,004	44	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	14,725,633	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	9,495,119	1,796,479,741		6,593,892	46,535	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035
Component CCN: 15-T035
Period: From 01/01/2018 To 12/31/2018
Worksheet D Part IV
Date/Time Prepared: 5/21/2019 3:36 pm
Title XVIII
Subprovider - IRF
PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	361,996,097	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	16,885,519	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	20,007,600	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	244,395,311	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	220,719,203	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	47,116,797	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,739,931	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,900,462	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,871,483	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	159,883,346	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	43,921,500	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	179,746,060	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	249,303,719	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,615,418	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	12,789,364	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	183,862,298	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	14,725,633	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	1,796,479,741		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	7,877	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	268,716	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	923,623	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,009	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,706,937	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,823,984	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	392,693	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	55,998	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	20,070	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,293	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,188,614	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	176,286	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.000000	19,788	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	5,004	0	510	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)		6,593,892	0	510	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0035
Component CCN: 15-T035

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

Worksheet D
Part V
Date/Time Prepared:
5/21/2019 3:36 pm

Title XVIII

Subprovider - IRF

PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.076005	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.285344	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.019151	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.075939	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.077017	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.079424	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.204787	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.097799	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.211710	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074996	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.013025	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.168621	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151454	0	0	3,678	0	73.00
74.00	07400	RENAL DIALYSIS	0.238433	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.217367	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.094144	510	0	0	48	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290768	0	0	0	0	92.00
200.00		Subtotal (see instructions)		510	0	3,678	48	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		510	0	3,678	48	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	557		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	557		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	557		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/21/2019 3:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.076005	0	0	20,441,754	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.285344	0	0	24,522	0	52.00
53.00	05300	ANESTHESIOLOGY	0.019151	0	0	1,177,683	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.075939	0	0	21,278,810	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.077017	0	0	15,061,823	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.079424	0	0	600,483	0	65.00
66.00	06600	PHYSICAL THERAPY	0.204787	0	0	992,361	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.097799	0	0	296,725	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.211710	0	0	609,412	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074996	0	0	8,921,703	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.013025	0	0	1,725,098	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.168621	0	0	4,575,938	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151454	0	0	13,983,801	0	73.00
74.00	07400	RENAL DIALYSIS	0.238433	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.217367	0	0	1,210,458	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.094144	0	0	36,735,029	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290768	0	0	1,370,389	0	92.00
200.00		Subtotal (see instructions)		0	0	129,005,989	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	129,005,989	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/21/2019 3:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,553,676		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,997		52.00
53.00	05300	ANESTHESIOLOGY	0	22,554		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,615,892		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	1,160,016		60.00
65.00	06500	RESPIRATORY THERAPY	0	47,693		65.00
66.00	06600	PHYSICAL THERAPY	0	203,223		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	29,019		67.00
68.00	06800	SPEECH PATHOLOGY	0	129,019		68.00
69.00	06900	ELECTROCARDIOLOGY	0	669,092		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	22,469		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	771,599		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,117,903		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	263,114		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	3,458,383		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	398,465		92.00
200.00		Subtotal (see instructions)	0	12,469,114		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	12,469,114		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	49,994	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	49,994	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)	45,108	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	19,626	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	43,811,087	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)	43,811,087	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	43,811,087	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	876.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	17,198,853	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)	17,198,853	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	11,507,984	6,088	1,890.27	2,900	5,481,783	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	3,696,587	2,983	1,239.22	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)	29,295,500	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	51,976,136	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,917,057	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,387,977	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,305,034	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	48,671,102	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)	4,886	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	876.33	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,281,748	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,991,359	43,811,087	0.091104	4,281,748	390,084	90.00
91.00	Nursing School cost	0	43,811,087	0.000000	4,281,748	0	91.00
92.00	Allied health cost	0	43,811,087	0.000000	4,281,748	0	92.00
93.00	All other Medical Education	0	43,811,087	0.000000	4,281,748	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0035 Component CCN: 15-T035	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/21/2019 3:36 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,077	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,077	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)	3,077	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)	2,017	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,364,431	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)	3,364,431	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,364,431	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,093.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,205,408	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)	2,205,408	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	934,962	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,140,370	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)	312,615	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	46,535	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	359,150	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,781,220	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0035
Component CCN: 15-T035

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

Worksheet D-1
Date/Time Prepared:
5/21/2019 3:36 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	476,918	3,364,431	0.141753	0	0	90.00
91.00	Nursing School cost	0	3,364,431	0.000000	0	0	91.00
92.00	Allied health cost	0	3,364,431	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,364,431	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		62,297,675		30.00
31.00	03100	INTENSIVE CARE UNIT		15,807,640		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0		31.01
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.076005	59,756,939	4,541,826	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.285344	50,752	14,482	52.00
53.00	05300	ANESTHESIOLOGY	0.019151	2,829,293	54,184	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.075939	23,146,866	1,757,750	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.077017	36,388,678	2,802,547	60.00
65.00	06500	RESPIRATORY THERAPY	0.079424	22,178,681	1,761,520	65.00
66.00	06600	PHYSICAL THERAPY	0.204787	5,421,072	1,110,165	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.097799	3,464,335	338,808	67.00
68.00	06800	SPEECH PATHOLOGY	0.211710	1,210,524	256,280	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074996	22,896,812	1,717,169	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.013025	8,715,008	113,513	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.168621	45,003,275	7,588,497	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151454	27,713,832	4,197,371	73.00
74.00	07400	RENAL DIALYSIS	0.238433	1,635,626	389,987	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.217367	164,513	35,760	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.094144	21,058,202	1,982,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290768	2,177,467	633,138	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		283,811,875	29,295,500	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)		283,811,875		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0		31.01
41.00	04100	SUBPROVIDER - IRF		5,724,246		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.076005	7,877	599	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.285344	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.019151	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.075939	268,716	20,406	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.077017	923,623	71,135	60.00
65.00	06500	RESPIRATORY THERAPY	0.079424	3,009	239	65.00
66.00	06600	PHYSICAL THERAPY	0.204787	1,706,937	349,559	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.097799	1,823,984	178,384	67.00
68.00	06800	SPEECH PATHOLOGY	0.211710	392,693	83,137	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074996	55,998	4,200	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.013025	20,070	261	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.168621	1,293	218	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151454	1,188,614	180,020	73.00
74.00	07400	RENAL DIALYSIS	0.238433	176,286	42,032	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.217367	19,788	4,301	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.094144	5,004	471	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290768	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,593,892	934,962	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)		6,593,892		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/21/2019 3:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		16,114,425		30.00
31.00	03100	INTENSIVE CARE UNIT		3,657,621		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		8,206,432		31.01
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		948,024		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.076005	13,811,843	1,049,769	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.285344	5,016,274	1,431,364	52.00
53.00	05300	ANESTHESIOLOGY	0.019151	1,102,931	21,122	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.075939	6,238,310	473,731	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.077017	10,308,930	793,963	60.00
65.00	06500	RESPIRATORY THERAPY	0.079424	1,449,725	115,143	65.00
66.00	06600	PHYSICAL THERAPY	0.204787	744,863	152,538	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.097799	345,272	33,767	67.00
68.00	06800	SPEECH PATHOLOGY	0.211710	118,520	25,092	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074996	4,425,657	331,907	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.013025	1,134,911	14,782	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.168621	3,348,240	564,584	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151454	7,852,725	1,189,327	73.00
74.00	07400	RENAL DIALYSIS	0.238433	283,945	67,702	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.217367	54,534	11,854	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.094144	5,804,931	546,499	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290768	613,906	178,504	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		62,655,517	7,001,648	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)		62,655,517		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/21/2019 3:36 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0		31.01
41.00	04100	SUBPROVIDER - IRF		405,834		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.076005	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.285344	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.019151	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.075939	5,415	411	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.077017	700,752	53,970	60.00
65.00	06500	RESPIRATORY THERAPY	0.079424	2,432,223	193,177	65.00
66.00	06600	PHYSICAL THERAPY	0.204787	119,407	24,453	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.097799	117,375	11,479	67.00
68.00	06800	SPEECH PATHOLOGY	0.211710	43,277	9,162	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074996	11,687	876	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.013025	392,200	5,108	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.168621	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151454	977,727	148,081	73.00
74.00	07400	RENAL DIALYSIS	0.238433	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.217367	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.094144	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.290768	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,800,063	446,717	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)		4,800,063		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/21/2019 3:36 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	30,090,775	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	9,838,251	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	1,074,839	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	14,231,756	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	224.61	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.68	30.00
31.00	Percentage of Medicaid patient days (see instructions)	16.93	31.00
32.00	Sum of lines 30 and 31	19.61	32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.50	33.00
34.00	Disproportionate share adjustment (see instructions)	549,024	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/21/2019 3:36 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000292002	0.000244290	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,975,889	2,020,980	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,477,856	509,398	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,987,254		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	43,540,143		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	43,540,143	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	3,435,509	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	36,661	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	47,012,313	59.00
60.00	Primary payer payments	20,182	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	46,992,131	61.00
62.00	Deductibles billed to program beneficiaries	3,931,892	62.00
63.00	Coinsurance billed to program beneficiaries	316,856	63.00
64.00	Allowable bad debts (see instructions)	477,753	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	310,539	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	74,053	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	43,053,922	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	29,098	70.93
70.94	HRR adjustment amount (see instructions)	-77,534	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Date/Time Prepared: 5/21/2019 3:36 pm

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)		43,005,486	71.00
71.01	Sequestration adjustment (see instructions)		860,110	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		41,833,341	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)		312,035	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,750,914	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/21/2019 3:36 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	35,308	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	33,842,522	2.00
3.00	OPPS payments	34,861,814	3.00
4.00	Outlier payment (see instructions)	101,146	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	35,308	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	233,225	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)	233,225	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	233,225	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	197,917	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)	35,308	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)	34,962,960	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	50,542	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6,250,038	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)	28,697,688	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	28,697,688	30.00
31.00	Primary payer payments	30,995	31.00
32.00	Subtotal (line 30 minus line 31)	28,666,693	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	722,802	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	469,821	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	517,360	36.00
37.00	Subtotal (see instructions)	29,136,514	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-1,330	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	29,137,844	40.00
40.01	Sequestration adjustment (see instructions)	582,757	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	28,463,009	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	92,078	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035 Component CCN: 15-T035	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/21/2019 3:36 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	557	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	48	2.00
3.00	OPPS payments	218	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	557	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	3,678	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)	3,678	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	3,678	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,121	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)	557	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)	218	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	775	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	775	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	775	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	118	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	77	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	118	36.00
37.00	Subtotal (see instructions)	852	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	852	40.00
40.01	Sequestration adjustment (see instructions)	17	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	934	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-99	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		41,791,341		28,437,309	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	07/09/2018	42,000	07/09/2018	25,700	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)		42,000		25,700	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)		41,833,341		28,463,009	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		312,035		92,078	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		42,145,376		28,555,087	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: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/21/2019 3:36 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,342,250		934	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,342,250		934	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		27,173		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		99	6.02
7.00	Total Medicare program liability (see instructions)		3,369,423		835	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: 15-0035	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/21/2019 3:36 pm
	Title XVIII	Hospital	PPS

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035 Component CCN: 15-T035	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part III Date/Time Prepared: 5/21/2019 3:36 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	3,320,827	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0401	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	86,674	3.00
4.00	Outlier Payments	50,699	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)	8.430137	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	3,458,200	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	3,458,200	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	3,458,200	19.00
20.00	Deductibles	4,020	20.00
21.00	Subtotal (line 19 minus line 20)	3,454,180	21.00
22.00	Coinsurance	32,160	22.00
23.00	Subtotal (line 21 minus line 22)	3,422,020	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	24,873	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	16,167	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,053	26.00
27.00	Subtotal (sum of lines 23 and 25)	3,438,187	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	3,438,187	32.00
32.01	Sequestration adjustment (see instructions)	68,764	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	3,342,250	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)	27,173	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	15,608	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	50,699	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/21/2019 3:36 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-610,934	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	75,933,186	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-17,259,450	0	0	0	6.00
7.00	Inventory	10,011,244	0	0	0	7.00
8.00	Prepaid expenses	970,815	0	0	0	8.00
9.00	Other current assets	-20,311	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	69,024,550	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	11,615,241	0	0	0	12.00
13.00	Land improvements	4,920,709	0	0	0	13.00
14.00	Accumulated depreciation	-2,680,627	0	0	0	14.00
15.00	Buildings	191,907,250	0	0	0	15.00
16.00	Accumulated depreciation	-31,922,631	0	0	0	16.00
17.00	Leasehold improvements	7,285,204	0	0	0	17.00
18.00	Accumulated depreciation	-2,323,802	0	0	0	18.00
19.00	Fixed equipment	6,843,132	0	0	0	19.00
20.00	Accumulated depreciation	-4,703,973	0	0	0	20.00
21.00	Automobiles and trucks	325,294	0	0	0	21.00
22.00	Accumulated depreciation	-316,172	0	0	0	22.00
23.00	Major movable equipment	56,056,036	0	0	0	23.00
24.00	Accumulated depreciation	-46,688,753	0	0	0	24.00
25.00	Minor equipment depreciable	17,325,843	0	0	0	25.00
26.00	Accumulated depreciation	-13,506,915	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)	194,135,836	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	7,839,640	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,839,640	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	271,000,026	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	12,565,927	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,877,742	0	0	0	38.00
39.00	Payroll taxes payable	55	0	0	0	39.00
40.00	Notes and loans payable (short term)	16,664	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-178,100,774	0	0	0	43.00
44.00	Other current liabilities	2,993,049	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-153,647,337	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	14,360,265	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,360,265	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-139,287,072	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	410,287,098				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	410,287,098	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	271,000,026	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/21/2019 3:36 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		371,719,797		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		38,567,301				2.00
3.00	Total (sum of line 1 and line 2)		410,287,098		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		410,287,098		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		410,287,098		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/21/2019 3:36 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	145,328,255		145,328,255	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	8,732,526		8,732,526	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)	154,060,781		154,060,781	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	33,823,290		33,823,290	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	18,158,105		18,158,105	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)	51,981,395		51,981,395	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	206,042,176		206,042,176	17.00
18.00	Ancillary services	638,310,398	959,581,412	1,597,891,810	18.00
19.00	Outpatient services	52,215,898	146,372,033	198,587,931	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)	896,568,472	1,105,953,445	2,002,521,917	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		283,025,354		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)		283,025,354		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0035	Period: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 5/21/2019 3:36 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	2,002,521,917	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,681,658,152	2.00
3.00	Net patient revenues (line 1 minus line 2)	320,863,765	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	283,025,354	4.00
5.00	Net income from service to patients (line 3 minus line 4)	37,838,411	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	728,890	24.00
25.00	Total other income (sum of lines 6-24)	728,890	25.00
26.00	Total (line 5 plus line 25)	38,567,301	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	38,567,301	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0035	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/21/2019 3:36 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	3,235,047	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	69,443	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)	150.07	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	2.68	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	16.93	8.00
9.00	Sum of lines 7 and 8	19.61	9.00
10.00	Allowable disproportionate share percentage (see instructions)	4.05	10.00
11.00	Disproportionate share adjustment (see instructions)	131,019	11.00
12.00	Total prospective capital payments (see instructions)	3,435,509	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00