

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: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/22/2019 7:59 am
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PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for Full or "L" for Low.

Contractor use only
 5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/22/2019 Time: 7:59 am

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 REID HOSPITAL & HEALTH CARE SERVICES (15-0048) 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 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	154,367	763,882	0	0	1.00
2.00 Subprovider - IPF	0	43,421	15		0	2.00
3.00 Subprovider - IRF	0	42,873	12		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	240,661	763,909	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: 15-0048		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/22/2019 7:59 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1401 CHESTER BOULEVARD			PO Box:							1.00	
2.00	City: RICHMOND			State: IN		Zip Code: 47374		County: WAYNE			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			REID HOSPITAL & HEALTH CARE SERVICES	150048	99915	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF			SUBPROVIDER	15S048	99915	4	01/01/2001	N	P	0	4.00
5.00	Subprovider - IRF			REHAB UNIT	15T048	99915	5	01/01/2003	N	P	0	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			HOSPICE	151524	99915		11/03/1993				14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:		To:			
							1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2018		12/31/2018		20.00	
21.00	Type of Control (see instructions)						2				21.00	
							1.00	2.00	3.00			
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y		Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N		N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N		N		N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							3		N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			878	219	229	427	6,749	118		24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0048		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/22/2019 7:59 am			
		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	103	0	0	378		25.00	
						Urban/Rural	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					1		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					01/01/2018	12/31/2018	36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
						NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
						1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)						23.00	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0048

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

Worksheet S-2
Part I
Date/Time Prepared:
5/22/2019 7:59 am

		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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N		0	71.00
					1.00	2.00	3.00
75.00	Inpatient Rehabilitation Facility PPS 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

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		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
		1.00			
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N			81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N			87.00
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.	N			92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

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		1.00		2.00			
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				140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	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 1.00		Part B 2.00		Title V 3.00	
						Title XIX 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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name 0		County 1.00		State 2.00	
						Zip Code 3.00	
						CBSA 4.00	
						FTE/Campus 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	
						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	
168.01	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	
		Beginning 1.00		Ending 2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2018		09/30/2018		170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/22/2019 7:59 am	
		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. 1, 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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0048		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part II Date/Time Prepared: 5/22/2019 7:59 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/24/2019			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	Y					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					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/04/2019	Y	04/04/2019		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/22/2019 7:59 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
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			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			Y	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.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KERRY		BEJARANO	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3173834000		KBEJARANO@BKD.COM	43.00

		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.	SENIOR MANAGING CONSULTANT	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: 15-0048

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

Worksheet S-3
Part I
Date/Time Prepared:
5/22/2019 7:59 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Ti tle 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	133	48,545	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)		133	48,545	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	30	10,950	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY					0	13.00
14.00 Total (see instructions)	43.00	163	59,495	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	38	13,870		0	16.00
17.00 SUBPROVIDER - IRF	41.00	20	7,300		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			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)		221				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: 15-0048

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

Worksheet S-3
Part I
Date/Time Prepared:
5/22/2019 7:59 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	18,584	716	32,282			1.00
2.00 HMO and other (see instructions)	2,922	7,624				2.00
3.00 HMO IPF Subprovider	698	1,825				3.00
4.00 HMO IRF Subprovider	146	481				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)	18,584	716	32,282			7.00
8.00 INTENSIVE CARE UNIT	2,657	117	5,246			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		45	2,015			13.00
14.00 Total (see instructions)	21,241	878	39,543	13.48	2,386.39	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	5,396	254	9,557	0.00	67.34	16.00
17.00 SUBPROVIDER - IRF	2,289	0	3,725	0.00	21.53	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	953	21	1,131	0.00	21.80	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)				13.48	2,497.06	27.00
28.00 Observation Bed Days		160	3,714			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			713			30.00
31.00 Employee discount days - IRF			15			31.00
32.00 Labor & delivery days (see instructions)	0	118	190			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: 15-0048

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

Worksheet S-3
Part I
Date/Time Prepared:
5/22/2019 7:59 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	5,641	231	10,402	1.00
2.00 HMO and other (see instructions)			611	2,006		2.00
3.00 HMO IPF Subprovider				144		3.00
4.00 HMO IRF Subprovider				33		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	5,641	231	10,402	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	420	0	752	16.00
17.00 SUBPROVIDER - IRF	0.00	0	168	0	258	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	0.00					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: 15-0048		Period: From 01/01/2018 To 12/31/2018		Worksheet S-3 Part II Date/Time Prepared: 5/22/2019 7:59 am	
	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	176,294,574	0	176,294,574	5,579,596.03	31.60	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	1,408,751	1,408,751	30,162.09	46.71	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)		81,171,544	663,064	81,834,608	1,841,645.12	44.44	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		6,045,841	0	6,045,841	125,839.39	48.04	11.00
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		376,493	0	376,493	2,653.85	141.87	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		24,754,313	0	24,754,313			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		14,429,044	0	14,429,044			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		245,282	0	245,282			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0048

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

Worksheet S-3
Part II
Date/Time Prepared:
5/22/2019 7:59 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	2,061,325	-420,080	1,641,245	61,776.93	26.57	26.00
27.00	Administrative & General	5.00	21,253,348	-3,886	21,249,462	849,796.44	25.01	27.00
28.00	Administrative & General under contract (see inst.)		8,422,169	0	8,422,169	104,035.50	80.95	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,757,758	6,649	2,764,407	124,286.34	22.24	30.00
31.00	Laundry & Linen Service	8.00	452,918	-108,448	344,470	24,537.84	14.04	31.00
32.00	Housekeeping	9.00	1,697,662	4,093	1,701,755	122,602.48	13.88	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,701,438	-2,202,740	498,698	34,944.39	14.27	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	2,209,253	2,209,253	138,101.62	16.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	216,509	216,509	2,080.00	104.09	38.00
39.00	Central Services and Supply	14.00	581,592	1,402	582,994	39,778.50	14.66	39.00
40.00	Pharmacy	15.00	3,910,478	9,428	3,919,906	119,374.98	32.84	40.00
41.00	Medical Records & Medical Records Library	16.00	3,683,356	8,881	3,692,237	214,224.47	17.24	41.00
42.00	Social Service	17.00	3,270,960	7,886	3,278,846	105,137.40	31.19	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0048

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

Worksheet S-3
Part III
Date/Time Prepared:
5/22/2019 7:59 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion 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)	184,716,743	-1,408,751	183,307,992	5,653,469.44	32.42	1.00
2.00	Excluded area salaries (see instructions)	81,171,544	663,064	81,834,608	1,841,645.12	44.44	2.00
3.00	Subtotal salaries (line 1 minus line 2)	103,545,199	-2,071,815	101,473,384	3,811,824.32	26.62	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,422,334	0	6,422,334	128,493.24	49.98	4.00
5.00	Subtotal wage-related costs (see inst.)	24,754,313	0	24,754,313	0.00	24.39	5.00
6.00	Total (sum of lines 3 thru 5)	134,721,846	-2,071,815	132,650,031	3,940,317.56	33.66	6.00
7.00	Total overhead cost (see instructions)	50,793,004	-271,053	50,521,951	1,940,676.89	26.03	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part IV Date/Time Prepared: 5/22/2019 7:59 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		5,059,814	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)		20,288,492	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		276,332	9.00
10.00	Dental, Hearing and Vision Plan		770,122	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		188,511	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		620,925	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		755,230	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		11,116,258	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		23,250	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		329,705	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		39,428,639	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: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part V Date/Time Prepared: 5/22/2019 7:59 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	6,045,841	39,428,639	1.00
2.00	Hospital	6,045,841	24,999,595	2.00
3.00	Subprovider - IPF	0	663,736	3.00
4.00	Subprovider - IRF	0	235,193	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	0	226,536	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	13,303,579	18.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA		Provider CCN: 15-0048 Hospice CCN: 15-1524	Period: From 01/01/2018 To 12/31/2018	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/22/2019 7:59 am
		Hospice I		

	Unduplicated Days	Hospice I					Total (sum of cols. 1, 2 & 5)	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other		
		1.00	2.00	3.00	4.00	5.00		
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	14,363	973	2,340	17,676	11.00
12.00	Hospice Inpatient Respite Care	97	9	0	106	12.00
13.00	Hospice General Inpatient Care	835	12	0	847	13.00
14.00	Total Hospice Days	15,295	994	2,340	18,629	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/22/2019 7:59 am
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				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)			0.302453	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			33,057,716	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00	
6.00	Medicaid charges			146,338,982	6.00	
7.00	Medicaid cost (line 1 times line 6)			44,260,664	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)			11,202,948	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP			0	9.00	
10.00	Stand-alone CHIP charges			0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			11,202,948	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)	11,736,198	2,232,034	13,968,232	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,549,648	2,232,034	5,781,682	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00	
23.00	Cost of charity care (line 21 minus line 22)	3,549,648	2,232,034	5,781,682	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)			24,015,183	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			1,651,329	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			2,540,505	27.01	
28.00	Non-Medicare bad debt expense (see instructions)			21,474,678	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			7,384,257	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			13,165,939	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			24,368,887	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0048		Period: From 01/01/2018 To 12/31/2018		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		0	0	19,800,290	19,800,290	1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE		0	0	6,563,534	6,563,534	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,061,325	31,596,670	33,657,995	13,508,241	47,166,236	4.00
5.01	00540	NONPATIENT TELEPHONES	271,841	22,298	294,139	655	294,794	5.01
5.02	00550	DATA PROCESSING	4,140,920	25,260,858	29,401,778	-2,246	29,399,532	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	913,443	804,289	1,717,732	1,455	1,719,187	5.03
5.04	00570	ADMINITTING	2,185,965	1,187,403	3,373,368	-9,906	3,363,462	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,444,634	5,250,708	8,695,342	-207,080	8,488,262	5.05
5.06	00590	OTHER A&G	10,296,545	34,824,066	45,120,611	-493,122	44,627,489	5.06
7.00	00700	OPERATION OF PLANT	2,757,758	1,083,995	3,841,753	-17,651	3,824,102	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	452,918	427,902	880,820	-229,991	650,829	8.00
9.00	00900	HOUSEKEEPING	1,697,662	592,412	2,290,074	4,093	2,294,167	9.00
10.00	01000	DIETARY	2,701,438	2,996,431	5,697,869	-4,647,258	1,050,611	10.00
11.00	01100	CAFETERIA	0	0	0	4,653,677	4,653,677	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	216,509	216,509	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	581,592	3,100,070	3,681,662	1,402	3,683,064	14.00
15.00	01500	PHARMACY	3,910,478	27,093,583	31,004,061	3,762	31,007,823	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,683,356	1,610,279	5,293,635	-4	5,293,631	16.00
17.00	01700	SOCIAL SERVICE	2,161,861	513,401	2,675,262	5,212	2,680,474	17.00
17.01	01701	INSERVICE EDUCATION	1,109,099	1,534,565	2,643,664	2,674	2,646,338	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,478,397	1,478,397	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,589,123	990,856	2,579,979	-1,474,566	1,105,413	22.00
23.00	02300	PARAMED PRGM	213,239	30,932	244,171	514	244,685	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,828,019	9,460,070	28,288,089	-379,009	27,909,080	30.00
31.00	03100	INTENSIVE CARE UNIT	3,825,880	2,485,432	6,311,312	9,224	6,320,536	31.00
40.00	04000	SUBPROVIDER - I PF	3,763,675	537,796	4,301,471	9,074	4,310,545	40.00
41.00	04100	SUBPROVIDER - I RF	1,330,301	345,720	1,676,021	3,207	1,679,228	41.00
43.00	04300	NURSERY	464,695	115,029	579,724	730	580,454	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,213,170	39,179,887	40,393,057	-9,049,925	31,343,132	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	736,922	298,101	1,035,023	-1,745	1,033,278	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,766,008	6,279,519	12,045,527	-122,810	11,922,717	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,817,573	9,826,216	11,643,789	-5,108,093	6,535,696	59.00
60.00	06000	LABORATORY	3,490,614	7,279,912	10,770,526	-28,360	10,742,166	60.00
65.00	06500	RESPIRATORY THERAPY	1,310,361	498,797	1,809,158	2,854	1,812,012	65.00
66.00	06600	PHYSICAL THERAPY	5,300,671	1,385,618	6,686,289	-206,225	6,480,064	66.00
69.00	06900	ELECTROCARDIOLOGY	824,008	754,662	1,578,670	1,885	1,580,555	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	337,529	78,520	416,049	814	416,863	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	14,187,239	14,187,239	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	773,055	773,055	0	773,055	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	218,237	81,096	299,333	-37,295	262,038	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,115,166	2,313,577	7,428,743	-271,865	7,156,878	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	1,776,572	415,116	2,191,688	-147,361	2,044,327	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	137,647	370,804	508,451	314	508,765	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		8,109,706	8,109,706	-8,109,706	0	113.00
116.00	11600	HOSPICE	930,183	1,489,156	2,419,339	408,218	2,827,557	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	101,360,428	230,998,507	332,358,935	30,319,756	362,678,691	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	9,231,926	9,231,926	-5,917,119	3,314,807	192.00
194.00	07950	RENTAL SPACE	0	14,977,856	14,977,856	-10,952,405	4,025,451	194.00
194.01	07951	FOUNDATION	179,415	288,897	468,312	433	468,745	194.01
194.02	07952	RETAIL SERVICES	124,080	17,383	141,463	299	141,762	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	231,083	231,083	194.03
194.04	07954	REID PHYSICIAN ASSOC.	73,596,288	43,156,039	116,752,327	-13,683,337	103,068,990	194.04
194.05	07955	OTHER NRCC	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.08	07958	CAMBRI DGE RHC	1,034,363	284,292	1,318,655	1,290	1,319,945	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	176,294,574	298,954,900	475,249,474	0	475,249,474	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0048

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

Worksheet A
Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-8,109,706	11,690,584	1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	0	6,563,534	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-16,183,796	30,982,440	4.00
5.01	00540	NONPATIENT TELEPHONES	0	294,794	5.01
5.02	00550	DATA PROCESSING	-472,008	28,927,524	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	-367,459	1,351,728	5.03
5.04	00570	ADMITTING	0	3,363,462	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	-11,685	8,476,577	5.05
5.06	00590	OTHER A&G	-15,884,439	28,743,050	5.06
7.00	00700	OPERATION OF PLANT	-839	3,823,263	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	650,829	8.00
9.00	00900	HOUSEKEEPING	0	2,294,167	9.00
10.00	01000	DIETARY	-566,269	484,342	10.00
11.00	01100	CAFETERIA	-3,168,889	1,484,788	11.00
13.00	01300	NURSING ADMINISTRATION	0	216,509	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-374	3,682,690	14.00
15.00	01500	PHARMACY	-237,806	30,770,017	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-52,704	5,240,927	16.00
17.00	01700	SOCIAL SERVICE	0	2,680,474	17.00
17.01	01701	INSERVICE EDUCATION	-1,168,137	1,478,201	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,478,397	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	-689,386	416,027	22.00
23.00	02300	PARAMED ED PRGM	-48,209	196,476	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-5,551,758	22,357,322	30.00
31.00	03100	INTENSIVE CARE UNIT	-85	6,320,451	31.00
40.00	04000	SUBPROVIDER - IPF	-35	4,310,510	40.00
41.00	04100	SUBPROVIDER - IRF	-3,931	1,675,297	41.00
43.00	04300	NURSERY	0	580,454	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-8,992,677	22,350,455	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-489	1,032,789	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-204,300	11,718,417	54.00
59.00	05900	CARDIAC CATHETERIZATION	-7,765	6,527,931	59.00
60.00	06000	LABORATORY	-868,294	9,873,872	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,812,012	65.00
66.00	06600	PHYSICAL THERAPY	-58,121	6,421,943	66.00
69.00	06900	ELECTROCARDIOLOGY	-56,070	1,524,485	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-522	416,341	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	14,187,239	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	773,055	74.00
76.00	03950	ANCILLARY - OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	-2,345	259,693	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-910,423	6,246,455	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	FAMILY PRACTICE	-1,122	2,043,205	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-336,706	172,059	96.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-1,298	2,826,259	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-63,957,647	298,721,044	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,314,807	192.00
194.00	07950	RENTAL SPACE	0	4,025,451	194.00
194.01	07951	FOUNDATION	0	468,745	194.01
194.02	07952	RETAIL SERVICES	0	141,762	194.02
194.03	07953	REID CONTRACTED SERVICES	0	231,083	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	103,068,990	194.04
194.05	07955	OTHER NRCC	0	0	194.05
194.06	07956	VACANT SPACE	0	0	194.06
194.08	07958	CAMBRIDGE RHC	0	1,319,945	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	-63,957,647	411,291,827	200.00

RECLASSIFICATIONS

Provider CCN: 15-0048

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

Worksheet A-6
Date/Time Prepared:
5/22/2019 7:59 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAPITAL EXPENSE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	11,651,155	1.00
2.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	6,031,898	2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	7,410	3.00
4.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	272,859	4.00
5.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	32,019	5.00
6.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	258,777	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
			0	18,254,118	
B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	2,203,939	2,444,424	1.00
			2,203,939	2,444,424	
C - LAUNDRY RECLASS					
1.00	REID CONTRACTED SERVICES	194.03	109,277	121,543	1.00
			109,277	121,543	
D - NURSING VP RECLASS					
1.00	NURSING ADMINISTRATION	13.00	215,988	0	1.00
			215,988	0	
E - OCCUPATIONAL MEDICINE RECLASS					
1.00	OTHER A&G	5.06	160,993	122,817	1.00
			160,993	122,817	
F - IMPLANTABLE DEVICES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	14,187,239	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
			0	14,187,239	
G - INTEREST RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	8,109,706	1.00
			0	8,109,706	
J - INTERN AND RESIDENT					
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	1,405,363	69,646	1.00
			1,405,363	69,646	
K - WORKERS COMP RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	755,230	1.00
2.00		0.00	0	0	2.00
			0	755,230	
L - RHPA BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	13,180,654	1.00
			0	13,180,654	
M - LT RECOGNITION RECLASS					
1.00	NONPATIENT TELEPHONES	5.01	655	0	1.00
2.00	DATA PROCESSING	5.02	9,984	0	2.00
3.00	PURCHASING RECEIVING AND STORES	5.03	2,202	0	3.00
4.00	ADMINITING	5.04	5,270	0	4.00

RECLASSIFICATIONS

Provider CCN: 15-0048

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

Worksheet A-6

Date/Time Prepared:
5/22/2019 7:59 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
5.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	8,305	0	5.00
6.00	OTHER A&G	5.06	24,693	0	6.00
7.00	OPERATION OF PLANT	7.00	6,649	0	7.00
8.00	LAUNDRY & LINEN SERVICE	8.00	829	0	8.00
9.00	HOUSEKEEPING	9.00	4,093	0	9.00
10.00	DIETARY	10.00	1,199	0	10.00
11.00	CAFETERIA	11.00	5,314	0	11.00
12.00	NURSING ADMINISTRATION	13.00	521	0	12.00
13.00	CENTRAL SERVICES & SUPPLY	14.00	1,402	0	13.00
14.00	PHARMACY	15.00	9,428	0	14.00
15.00	MEDICAL RECORDS & LIBRARY	16.00	8,881	0	15.00
16.00	SOCIAL SERVICE	17.00	5,212	0	16.00
17.00	INSERVICE EDUCATION	17.01	2,674	0	17.00
18.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	3,388	0	18.00
19.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	443	0	19.00
20.00	PARAMED ED PRGM	23.00	514	0	20.00
21.00	ADULTS & PEDIATRICS	30.00	44,535	0	21.00
22.00	INTENSIVE CARE UNIT	31.00	9,224	0	22.00
23.00	SUBPROVIDER - IPF	40.00	9,074	0	23.00
24.00	SUBPROVIDER - IRF	41.00	3,207	0	24.00
25.00	NURSERY	43.00	1,120	0	25.00
26.00	OPERATING ROOM	50.00	2,925	0	26.00
27.00	DELIVERY ROOM & LABOR ROOM	52.00	1,777	0	27.00
28.00	RADIOLOGY-DIAGNOSTIC	54.00	13,902	0	28.00
29.00	CARDIAC CATHETERIZATION	59.00	4,382	0	29.00
30.00	LABORATORY	60.00	8,416	0	30.00
31.00	RESPIRATORY THERAPY	65.00	3,159	0	31.00
32.00	PHYSICAL THERAPY	66.00	12,780	0	32.00
33.00	ELECTROCARDIOLOGY	69.00	1,987	0	33.00
34.00	ELECTROENCEPHALOGRAPHY	70.00	814	0	34.00
35.00	CARDIAC REHABILITATION	76.97	526	0	35.00
36.00	EMERGENCY	91.00	11,945	0	36.00
37.00	FAMILY PRACTICE	93.00	4,283	0	37.00
38.00	DURABLE MEDICAL EQUIP-RENTED	96.00	332	0	38.00
39.00	HOSPICE	116.00	3,103	0	39.00
40.00	FOUNDATION	194.01	433	0	40.00
41.00	RETAIL SERVICES	194.02	299	0	41.00
42.00	REID CONTRACTED SERVICES	194.03	263	0	42.00
43.00	REID PHYSICIAN ASSOC.	194.04	177,444	0	43.00
44.00	CAMBRI DGE RHC	194.08	2,494	0	44.00
	TOTALS		420,080	0	
	N - HOSPICE				
1.00	HOSPICE	116.00	356,956	49,809	1.00
	TOTALS		356,956	49,809	
500.00	Grand Total: Increases		4,872,596	57,295,186	500.00

RECLASSIFICATIONS

Provider CCN: 15-0048

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

Worksheet A-6
Date/Time Prepared:
5/22/2019 7:59 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAPITAL EXPENSE RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,563	9	1.00	
2.00	DATA PROCESSING	5.02	0	12,230	9	2.00	
3.00	PURCHASING RECEIVING AND STORES	5.03	0	747	13	3.00	
4.00	ADMINISTRATIVE	5.04	0	15,176	13	4.00	
5.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	215,385	10	5.00	
6.00	OTHER A&G	5.06	0	61,858	10	6.00	
7.00	OPERATION OF PLANT	7.00	0	24,300	0	7.00	
8.00	DIETARY	10.00	0	94	0	8.00	
9.00	PHARMACY	15.00	0	5,666	0	9.00	
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	8,885	0	10.00	
11.00	ADULTS & PEDIATRICS	30.00	0	16,779	0	11.00	
12.00	OPERATING ROOM	50.00	0	3,036	0	12.00	
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	115,674	0	13.00	
14.00	LABORATORY	60.00	0	36,776	0	14.00	
15.00	RESPIRATORY THERAPY	65.00	0	305	0	15.00	
16.00	PHYSICAL THERAPY	66.00	0	219,005	0	16.00	
17.00	ELECTROCARDIOLOGY	69.00	0	102	0	17.00	
18.00	CARDIAC REHABILITATION	76.97	0	37,821	0	18.00	
19.00	FAMILY PRACTICE	93.00	0	151,644	0	19.00	
20.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	18	0	20.00	
21.00	HOSPICE	116.00	0	1,650	0	21.00	
22.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,917,119	0	22.00	
23.00	RENTAL SPACE	194.00	0	10,952,405	0	23.00	
24.00	REID PHYSICIAN ASSOC.	194.04	0	448,676	0	24.00	
25.00	CAMBRIDGE_RHC	194.08	0	1,204	0	25.00	
	O			18,254,118			
B - CAFETERIA RECLASS							
1.00	DIETARY	10.00	2,203,939	2,444,424	0	1.00	
	O		2,203,939	2,444,424			
C - LAUNDRY RECLASS							
1.00	LAUNDRY & LINEN SERVICE	8.00	109,277	121,543	0	1.00	
	O		109,277	121,543			
D - NURSING VP RECLASS							
1.00	OTHER A&G	5.06	215,988	0	0	1.00	
	O		215,988	0			
E - OCCUPATIONAL MEDICINE RECLASS							
1.00	EMERGENCY	91.00	160,993	122,817	0	1.00	
	O		160,993	122,817			
F - IMPLANTABLE DEVICES RECLASS							
1.00	NURSERY	43.00	0	390	0	1.00	
2.00	OPERATING ROOM	50.00	0	9,049,814	0	2.00	
3.00	DELIVERY ROOM & LABOR ROOM	52.00	0	3,522	0	3.00	
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	21,038	0	4.00	
5.00	CARDIAC CATHETERIZATION	59.00	0	5,112,475	0	5.00	
	O			14,187,239			
G - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	8,109,706	11	1.00	
	O			8,109,706			
J - INTERN AND RESIDENT							
1.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	1,405,363	69,646	0	1.00	
	O		1,405,363	69,646			
K - WORKERS COMP RECLASS							
1.00	OTHER A&G	5.06	0	523,779	0	1.00	
2.00	REID PHYSICIAN ASSOC.	194.04	0	231,451	0	2.00	
	O			755,230			
L - RHPA BENEFITS RECLASS							
1.00	REID PHYSICIAN ASSOC.	194.04	0	13,180,654	0	1.00	
	O			13,180,654			
M - LT RECOGNITION RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	420,080	0	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
4.00		0.00	0	0	0	4.00	
5.00		0.00	0	0	0	5.00	
6.00		0.00	0	0	0	6.00	
7.00		0.00	0	0	0	7.00	
8.00		0.00	0	0	0	8.00	
9.00		0.00	0	0	0	9.00	
10.00		0.00	0	0	0	10.00	
11.00		0.00	0	0	0	11.00	

Provider CCN: 15-0048

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

Worksheet A-6
Date/Time Prepared:
5/22/2019 7:59 am

Decreases								
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.				
6.00	7.00	8.00	9.00	10.00				
12.00	0.00	0	0	0			12.00	
13.00	0.00	0	0	0			13.00	
14.00	0.00	0	0	0			14.00	
15.00	0.00	0	0	0			15.00	
16.00	0.00	0	0	0			16.00	
17.00	0.00	0	0	0			17.00	
18.00	0.00	0	0	0			18.00	
19.00	0.00	0	0	0			19.00	
20.00	0.00	0	0	0			20.00	
21.00	0.00	0	0	0			21.00	
22.00	0.00	0	0	0			22.00	
23.00	0.00	0	0	0			23.00	
24.00	0.00	0	0	0			24.00	
25.00	0.00	0	0	0			25.00	
26.00	0.00	0	0	0			26.00	
27.00	0.00	0	0	0			27.00	
28.00	0.00	0	0	0			28.00	
29.00	0.00	0	0	0			29.00	
30.00	0.00	0	0	0			30.00	
31.00	0.00	0	0	0			31.00	
32.00	0.00	0	0	0			32.00	
33.00	0.00	0	0	0			33.00	
34.00	0.00	0	0	0			34.00	
35.00	0.00	0	0	0			35.00	
36.00	0.00	0	0	0			36.00	
37.00	0.00	0	0	0			37.00	
38.00	0.00	0	0	0			38.00	
39.00	0.00	0	0	0			39.00	
40.00	0.00	0	0	0			40.00	
41.00	0.00	0	0	0			41.00	
42.00	0.00	0	0	0			42.00	
43.00	0.00	0	0	0			43.00	
44.00	0.00	0	0	0			44.00	
TOTALS		420,080	0					
N - HOSPICE								
1.00	ADULTS & PEDIATRICS	30.00	356,956	49,809	0		1.00	
	TOTALS		356,956	49,809				
500.00	Grand Total: Decreases		4,872,596	57,295,186			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0048

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

Worksheet A-7
Part I
Date/Time Prepared:
5/22/2019 7:59 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	14,477,094	0	0	0	0	1.00
2.00	Land Improvements	38,224,615	0	0	0	23,235,405	2.00
3.00	Buildings and Fixtures	292,529,105	4,681,533	0	4,681,533	0	3.00
4.00	Building Improvements	12,484,100	0	0	0	25,653	4.00
5.00	Fixed Equipment	2,103,825	78,410	0	78,410	0	5.00
6.00	Movable Equipment	173,697,797	8,854,403	0	8,854,403	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	533,516,536	13,614,346	0	13,614,346	23,261,058	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	533,516,536	13,614,346	0	13,614,346	23,261,058	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	14,477,094	0				1.00
2.00	Land Improvements	14,989,210	0				2.00
3.00	Buildings and Fixtures	297,210,638	0				3.00
4.00	Building Improvements	12,458,447	0				4.00
5.00	Fixed Equipment	2,182,235	0				5.00
6.00	Movable Equipment	182,552,200	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	523,869,824	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	523,869,824	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0048

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

Worksheet A-7
Part II
Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0048

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

Worksheet A-7
Part III
Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	341,317,624	0	341,317,624	0.651531	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	182,552,200	0	182,552,200	0.348469	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	523,869,824	0	523,869,824	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	11,651,155	32,019	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	0	6,031,898	258,777	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	17,683,053	290,796	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	7,410	0	11,690,584	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	272,859	0	6,563,534	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	280,269	0	18,254,118	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0048

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

Worksheet A-8

Date/Time Prepared:
5/22/2019 7:59 am

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.	
			3.00	4.00	5.00	
1.00	2.00	3.00	4.00	5.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01 Investment income - NEW CAP BLDG & FIXT - OFFSITE (chapter 2)			ONEW CAP BLDG & FIXT - OFFSITE	1.01	0	1.01
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-287,959	PURCHASING RECEIVING AND STORES	5.03	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-11,557,816			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-5,511,298			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-3,168,889	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-79,500	PURCHASING RECEIVING AND STORES	5.03	0	16.00
17.00 Sale of drugs to other than patients	B	-15,797	PHARMACY	15.00	0	17.00
18.00 Sale of medical records and abstracts	B	-52,704	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	B	-15,339	DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01 Depreciation - NEW CAP BLDG & FIXT - OFFSITE			ONEW CAP BLDG & FIXT - OFFSITE	1.01	0	26.01
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant				0.00	0	29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0048

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

Worksheet A-8

Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 MISCELLANEOUS INCOME	B	-549,488	DIETARY	10.00	0	33.00
33.01 MISCELLANEOUS INCOME	B	-497,252	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02 MISCELLANEOUS INCOME	B	-472,008	DATA PROCESSING	5.02	0	33.02
33.03 MISCELLANEOUS INCOME	B	-1,323,534	OTHER A&G	5.06	0	33.03
33.04 MISCELLANEOUS INCOME	B	-839	OPERATION OF PLANT	7.00	0	33.04
33.05 MISCELLANEOUS INCOME	B	-222,009	PHARMACY	15.00	0	33.05
33.06 MISCELLANEOUS INCOME	B	-97,499	INSERVICE EDUCATION	17.01	0	33.06
33.07 MISCELLANEOUS INCOME	B	-44,230	PARAMED ED PRGM	23.00	0	33.07
33.08 MISCELLANEOUS INCOME	B	-12,000	ADULTS & PEDIATRICS	30.00	0	33.08
33.09 MISCELLANEOUS INCOME	B	-53,500	PHYSICAL THERAPY	66.00	0	33.09
33.10 MISCELLANEOUS INCOME	B	-162,266	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11 MISCELLANEOUS INCOME	B	-15,940	LABORATORY	60.00	0	33.11
33.12 MISCELLANEOUS INCOME	B	-336,718	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.12
33.13 MISCELLANEOUS INCOME	B	-6,775	CARDIAC CATHETERIZATION	59.00	0	33.13
33.14 INTEREST INCOME	B	-3,531,777	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.14
33.15 UNNECESSARY BORROWING	A	-4,577,929	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.15
33.16 SELF INSURANCE ADJUSTMENT	A	-15,658,246	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17 PATIENT ENTERTAINMENT SYSTEM	A	-132,261	OTHER A&G	5.06	0	33.17
33.18 COUNTRY CLUB DUES	A	-6,553	OTHER A&G	5.06	0	33.18
33.19 AHA/IIHA LOBBYING	A	-17,766	OTHER A&G	5.06	0	33.19
33.20 MARKETING/ADVERTISING	A	-21,911	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21 MARKETING/ADVERTISING	A	-563	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	33.21
33.22 MARKETING/ADVERTISING	A	-1,892,656	OTHER A&G	5.06	0	33.22
33.23 MARKETING/ADVERTISING	A	-1,402	DIETARY	10.00	0	33.23
33.24 MARKETING/ADVERTISING	A	-20,812	INSERVICE EDUCATION	17.01	0	33.24
33.25 MARKETING/ADVERTISING	A	-3,142	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	33.25
33.26 MARKETING/ADVERTISING	A	-4,117	ADULTS & PEDIATRICS	30.00	0	33.26
33.27 MARKETING/ADVERTISING	A	-3,338	SUBPROVIDER - IRF	41.00	0	33.27
33.28 MARKETING/ADVERTISING	A	-754	RADIOLOGY-DIAGNOSTIC	54.00	0	33.28
33.29 MARKETING/ADVERTISING	A	-990	CARDIAC CATHETERIZATION	59.00	0	33.29
33.30 MARKETING/ADVERTISING	A	-4,175	PHYSICAL THERAPY	66.00	0	33.30
33.31 MARKETING/ADVERTISING	A	-522	ELECTROENCEPHALOGRAPHY	70.00	0	33.31
33.32 MARKETING/ADVERTISING	A	-2,345	CARDIAC REHABILITATION	76.97	0	33.32
33.33 MARKETING/ADVERTISING	A	-13,024	EMERGENCY	91.00	0	33.33
33.34 MARKETING/ADVERTISING	A	-1,112	FAMILY PRACTICE	93.00	0	33.34
33.35 MARKETING/ADVERTISING	A	12	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.35
33.36 MARKETING/ADVERTISING	A	-982	HOSPICE	116.00	0	33.36
33.37 NON-ALLOWABLE EXPENSES	A	-6,387	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.37
33.38 NON-ALLOWABLE EXPENSES	A	-11,122	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	33.38
33.39 NON-ALLOWABLE EXPENSES	A	-1,498,982	OTHER A&G	5.06	0	33.39
33.40 NON-ALLOWABLE EXPENSES	A	-40	DIETARY	10.00	0	33.40
33.41 NON-ALLOWABLE EXPENSES	A	-374	CENTRAL SERVICES & SUPPLY	14.00	0	33.41
33.42 NON-ALLOWABLE EXPENSES	A	-964,886	INSERVICE EDUCATION	17.01	0	33.42
33.43 NON-ALLOWABLE EXPENSES	A	-591	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	33.43
33.44 NON-ALLOWABLE EXPENSES	A	-3,979	PARAMED ED PRGM	23.00	0	33.44
33.45 NON-ALLOWABLE EXPENSES	A	-8,380	ADULTS & PEDIATRICS	30.00	0	33.45
33.46 NON-ALLOWABLE EXPENSES	A	-85	INTENSIVE CARE UNIT	31.00	0	33.46
33.47 NON-ALLOWABLE EXPENSES	A	-35	SUBPROVIDER - IPF	40.00	0	33.47
33.48 NON-ALLOWABLE EXPENSES	A	-218	SUBPROVIDER - IRF	41.00	0	33.48
33.49 NON-ALLOWABLE EXPENSES	A	-1,330	OPERATING ROOM	50.00	0	33.49

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0048

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

Worksheet A-8

Date/Time Prepared:
5/22/2019 7:59 am

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
33.50 NON-ALLOWABLE EXPENSES	A	-489	DELIVERY ROOM & LABOR ROOM	52.00	0	33.50
33.51 NON-ALLOWABLE EXPENSES	A	-446	PHYSICAL THERAPY	66.00	0	33.51
33.52 NON-ALLOWABLE EXPENSES	A	-2,657	EMERGENCY	91.00	0	33.52
33.53 NON-ALLOWABLE EXPENSES	A	-10	FAMILY PRACTICE	93.00	0	33.53
33.54 NON-ALLOWABLE EXPENSES	A	-316	HOSPICE	116.00	0	33.54
33.55 HAF EXPENSE	A	-11,421,955	OTHER A&G	5.06	0	33.55
33.56 BOND REFUNDING - 2015 BONDS	A	401,531	OTHER A&G	5.06	0	33.56
33.57 BOND REFUNDING - 2016 BONDS	A	7,737	OTHER A&G	5.06	0	33.57
33.58 OCC MED - EMPLOYEE COST	A	-64,908	EMERGENCY	91.00	0	33.58
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-63,957,647				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: 15-0048
 Period: From 01/01/2018 To 12/31/2018
 Worksheet A-8-1
 Date/Time Prepared: 5/22/2019 7:59 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	18,893,683	24,404,981	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
4.01	0.00		0	0	4.01
4.02	0.00		0	0	4.02
5.00	0	0	18,893,683	24,404,981	5.00

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

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

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

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

6.00	A	REID O/P SURGER	55.00	0.00	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: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/22/2019 7:59 am
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	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	-5,511,298	0	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
5.00	-5,511,298		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		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: 15-0048

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

Worksheet A-8-2

Date/Time Prepared:
5/22/2019 7:59 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	17.01	INSERVICE EDUCATION	141,738	55,300	86,438	179,000	660	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	685,653	685,653	0	179,000	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	5,527,261	5,527,261	0	197,500	0	3.00
4.00	41.00	SUBPROVIDER - IRF	375	375	0	179,000	0	4.00
5.00	50.00	OPERATING ROOM	3,480,049	3,480,049	0	179,000	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	41,280	41,280	0	246,400	0	6.00
7.00	60.00	LABORATORY	852,354	852,354	0	260,300	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	56,070	56,070	0	260,300	0	8.00
9.00	91.00	EMERGENCY	829,834	829,834	0	179,000	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			11,614,614	11,528,176	86,438		660	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	17.01	INSERVICE EDUCATION	56,798	2,840	0	0	0	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			56,798	2,840	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	17.01	INSERVICE EDUCATION	0	56,798	29,640	84,940		1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	685,653		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	5,527,261		3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	375		4.00
5.00	50.00	OPERATING ROOM	0	0	0	3,480,049		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	41,280		6.00
7.00	60.00	LABORATORY	0	0	0	852,354		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	56,070		8.00
9.00	91.00	EMERGENCY	0	0	0	829,834		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	56,798	29,640	11,557,816		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

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

Worksheet B
Part I
Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP		
		1.00	1.01	2.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	11,690,584	11,690,584			1.00
1.01 00101	NEW CAP BLDG & FIXT - OFFSITE	6,563,534	0	6,563,534		1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	30,982,440		9,531	0	31,034,369
5.01 00540	NONPATIENT TELEPHONES	294,794	60,332	0	0	48,420
5.02 00550	DATA PROCESSING	28,927,524	198,851	26,092	0	737,578
5.03 00560	PURCHASING RECEIVING AND STORES	1,351,728	248,603	0	0	162,702
5.04 00570	ADMITTING	3,363,462	2,287	44,892	0	389,363
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	8,476,577	12,946	194,436	0	613,556
5.06 00590	OTHER A&G	28,743,050	398,528	168,106	0	1,824,219
7.00 00700	OPERATION OF PLANT	3,823,263	2,893,778	99,076	0	491,210
8.00 00800	LAUNDRY & LINEN SERVICE	650,829	195,944	0	0	61,209
9.00 00900	HOUSEKEEPING	2,294,167	107,638	0	0	302,387
10.00 01000	DIETARY	484,342	199,645	0	0	88,614
11.00 01100	CAFETERIA	1,484,788	156,835	0	0	392,564
13.00 01300	NURSING ADMINISTRATION	216,509	31,056	0	0	38,472
14.00 01400	CENTRAL SERVICES & SUPPLY	3,682,690	133,610	0	0	103,593
15.00 01500	PHARMACY	30,770,017	115,501	0	0	696,532
16.00 01600	MEDICAL RECORDS & LIBRARY	5,240,927	55,709	140,179	0	656,077
17.00 01700	SOCIAL SERVICE	2,680,474	19,714	0	0	385,069
17.01 01701	INSERVICE EDUCATION	1,478,201	165,349	0	0	197,552
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,478,397	0	0	0	250,322
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	416,027	0	0	0	32,731
23.00 02300	PARAMED PRGM	196,476	16,854	63,859	0	37,982
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	22,357,322	1,735,394	0	0	3,290,055
31.00 03100	INTENSIVE CARE UNIT	6,320,451	390,013	0	0	681,463
40.00 04000	SUBPROVIDER - I PF	4,310,510	354,875	0	0	670,384
41.00 04100	SUBPROVIDER - I RF	1,675,297	284,313	0	0	236,952
43.00 04300	NURSERY	580,454	42,588	0	0	82,771
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	22,350,455	769,892	311,931	0	216,089
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,032,789	132,101	0	0	131,260
54.00 05400	RADIOLOGY-DIAGNOSTIC	11,718,417	965,502	38,125	0	1,027,038
59.00 05900	CARDIAC CATHETERIZATION	6,527,931	215,705	0	0	323,745
60.00 06000	LABORATORY	9,873,872	221,519	0	0	621,746
65.00 06500	RESPIRATORY THERAPY	1,812,012	26,163	0	0	233,401
66.00 06600	PHYSICAL THERAPY	6,421,943	128,416	1,008,301	0	944,152
69.00 06900	ELECTROCARDIOLOGY	1,524,485	111,371	0	0	146,772
70.00 07000	ELECTROENCEPHALOGRAPHY	416,341	0	92,738	0	60,121
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	14,187,239	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00 07400	RENAL DIALYSIS	773,055	23,669	0	0	0
76.00 03950	ANCILLARY - OTHER	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	259,693	71,849	0	0	38,872
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	6,246,455	361,738	0	0	882,434
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00 04040	FAMILY PRACTICE	2,043,205	141,934	20,182	0	316,442
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	172,059	28,180	68,434	0	24,518
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	2,826,259	7,069	0	0	229,264
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	298,721,044	11,067,869	2,285,882	0	17,667,631
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	3,314,807	3,955	58,521	0	0
194.00 07950	RENTAL SPACE	4,025,451	0	453,445	0	0
194.01 07951	FOUNDATION	468,745	3,272	0	0	31,957
194.02 07952	RETAIL SERVICES	141,762	37,171	0	0	22,101
194.03 07953	REID CONTRACTED SERVICES	231,083	0	0	0	19,464
194.04 07954	REID PHYSICIAN ASSOC.	103,068,990	547,865	3,356,609	0	13,108,976
194.05 07955	OTHER NRCC	0	8,451	0	0	0
194.06 07956	VACANT SPACE	0	22,001	409,077	0	0
194.08 07958	CAMBRI DGE RHC	1,319,945	0	0	0	184,240
200.00	Cross Foot Adjustments					

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

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

Worksheet B
Part I
Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	411,291,827	11,690,584	6,563,534	0	31,034,369	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0048		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part I Date/Time Prepared: 5/22/2019 7:59 am	
Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINING	CASHIERING/AC COUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	403,546					5.01
5.02	00550	DATA PROCESSING	42,487	29,932,532				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	5,642	3,120,430	4,889,105			5.03
5.04	00570	ADMINING	15,867	458,887	6,402	4,281,160		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	24,858	196,666	10,928	0	9,529,967	5.05
5.06	00590	OTHER A&G	20,803	367,109	43,594	0	0	5.06
7.00	00700	OPERATION OF PLANT	10,225	0	46,134	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,058	26,222	888	0	0	8.00
9.00	00900	HOUSEKEEPING	1,058	39,333	86,036	0	0	9.00
10.00	01000	DIETARY	15,514	445,776	67,556	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,173	183,555	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,763	157,333	563,993	0	0	14.00
15.00	01500	PHARMACY	7,581	524,442	440,885	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,988	1,101,328	11,426	0	0	16.00
17.00	01700	SOCIAL SERVICE	5,994	367,109	5,493	0	0	17.00
17.01	01701	INSERVICE EDUCATION	8,110	1,940,436	11,289	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	1,391	0	0	22.00
23.00	02300	PARAMED ED PRGM	529	131,111	1,000	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	40,196	3,120,430	404,110	272,187	605,850	30.00
31.00	03100	INTENSIVE CARE UNIT	9,167	458,887	192,804	48,603	108,182	31.00
40.00	04000	SUBPROVIDER - IPF	3,879	196,666	48,124	54,424	121,139	40.00
41.00	04100	SUBPROVIDER - IRF	5,642	367,109	31,270	21,210	47,211	41.00
43.00	04300	NURSERY	0	0	38,696	10,850	24,151	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,320	1,140,662	690,372	788,099	1,754,912	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,581	419,554	60,126	44,881	99,900	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,974	1,992,880	486,707	650,674	1,448,306	54.00
59.00	05900	CARDIAC CATHETERIZATION	5,113	131,111	369,190	489,841	1,090,316	59.00
60.00	06000	LABORATORY	11,283	760,441	59,314	426,365	949,028	60.00
65.00	06500	RESPIRATORY THERAPY	1,058	157,333	167,118	137,512	306,083	65.00
66.00	06600	PHYSICAL THERAPY	15,867	1,363,549	22,622	86,182	191,829	66.00
69.00	06900	ELECTROCARDIOLOGY	1,587	642,442	64,090	129,764	288,837	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,234	104,888	8,920	19,256	42,862	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	192	428	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	142,053	316,190	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	535,106	1,191,068	73.00
74.00	07400	RENAL DIALYSIS	881	26,222	10,040	4,933	10,981	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,116	26,222	5,279	4,599	10,237	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	14,456	983,329	198,734	352,688	785,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	10,049	511,331	35,510	32,532	72,411	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	4,407	157,333	48,958	1,327	2,953	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,292	39,333	78,110	27,882	62,061	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	373,752	21,659,459	4,317,109	4,281,160	9,529,967	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	11,459	13,111	4,844	0	0	192.00
194.00	07950	RENTAL SPACE	17,101	0	66,758	0	0	194.00
194.01	07951	FOUNDATION	1,234	78,666	4,596	0	0	194.01
194.02	07952	RETAIL SERVICES	0	471,998	1,582	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	7,709,298	484,477	0	0	194.04
194.05	07955	OTHER NRCC	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.08	07958	CAMBRIDGE RHC	0	0	9,739	0	0	194.08
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)	403,546	29,932,532	4,889,105	4,281,160	9,529,967	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Prepared: 5/22/2019 7:59 am			
Cost Center Description			Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.05	5.06	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G	31,565,409	31,565,409				5.06
7.00	00700	OPERATION OF PLANT	7,363,686	612,121	7,975,807			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	936,150	77,819	158,408	1,172,377		8.00
9.00	00900	HOUSEKEEPING	2,830,619	235,301	83,345	0	3,149,265	9.00
10.00	01000	DIETARY	1,301,447	108,185	141,713	0	71,880	10.00
11.00	01100	CAFETERIA	2,034,187	169,096	126,790	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	472,765	39,300	25,106	0	3,771	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,642,982	385,957	108,015	0	4,713	14.00
15.00	01500	PHARMACY	32,554,958	2,706,196	90,409	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,217,634	599,980	14,923	0	11,784	16.00
17.00	01700	SOCIAL SERVICE	3,463,853	287,940	5,625	0	17,911	17.00
17.01	01701	INSERVICE EDUCATION	3,800,937	315,960	119,714	0	44,777	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,728,719	143,703	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	450,149	37,420	0	0	0	22.00
23.00	02300	PARAMED PRGM	447,811	37,225	36,048	0	19,089	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,825,544	2,645,562	1,388,747	347,801	1,063,817	30.00
31.00	03100	INTENSIVE CARE UNIT	8,209,570	682,437	315,300	77,751	205,740	31.00
40.00	04000	SUBPROVIDER - IPF	5,760,001	478,812	286,893	64,054	178,874	40.00
41.00	04100	SUBPROVIDER - IRF	2,669,004	221,866	229,848	32,706	102,752	41.00
43.00	04300	NURSERY	779,510	64,798	34,430	0	3,299	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	28,055,732	2,332,189	521,698	189,241	277,149	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,928,192	160,285	106,795	61,753	45,013	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,354,623	1,525,765	564,026	120,109	129,854	54.00
59.00	05900	CARDIAC CATHETERIZATION	9,152,952	760,857	58,984	67,315	37,943	59.00
60.00	06000	LABORATORY	12,923,568	1,074,297	174,319	0	129,383	60.00
65.00	06500	RESPIRATORY THERAPY	2,840,680	236,137	15,333	0	28,280	65.00
66.00	06600	PHYSICAL THERAPY	10,182,861	846,471	619,247	8,224	22,153	66.00
69.00	06900	ELECTROCARDIOLOGY	2,909,348	241,845	7,153	0	47,841	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	746,360	62,043	69,347	4,891	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	620	52	0	0	25,452	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,645,482	1,217,435	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,726,174	143,492	0	0	35,351	73.00
74.00	07400	RENAL DIALYSIS	849,781	70,640	19,135	0	39,593	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	418,867	34,819	0	0	11,784	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	9,824,866	816,712	292,441	164,237	249,104	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04040	FAMILY PRACTICE	3,183,596	264,643	5,201	34,295	54,204	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	508,169	42,243	48,184	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,272,270	272,014	0	0	31,816	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	271,579,076	19,951,617	5,667,177	1,172,377	2,893,327	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	3,406,697	283,189	31,540	0	0	192.00
194.00	07950	RENTAL SPACE	4,562,755	379,288	287,920	0	0	194.00
194.01	07951	FOUNDATION	588,470	48,918	2,645	0	1,885	194.01
194.02	07952	RETAIL SERVICES	674,614	56,079	8,784	0	2,357	194.02
194.03	07953	REID CONTRACTED SERVICES	250,547	20,827	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	128,276,215	10,663,106	1,666,962	0	251,696	194.04
194.05	07955	OTHER NRCC	8,451	703	6,832	0	0	194.05
194.06	07956	VACANT SPACE	431,078	35,834	303,947	0	0	194.06
194.08	07958	CAMBRIDGE RHC	1,513,924	125,848	0	0	0	194.08
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	411,291,827	31,565,409	7,975,807	1,172,377	3,149,265	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0048		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part I Date/Time Prepared: 5/22/2019 7:59 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,623,225					10.00
11.00	01100	CAFETERIA	0	2,330,073				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,218	542,160			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,904	0	5,163,571		14.00
15.00	01500	PHARMACY	0	67,987	0	2,643	35,422,193	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	109,352	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	37,651	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	0	22,890	0	11	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	17,657	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	4,045	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	3,120	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,049,257	376,546	235,663	5,944	4,279	30.00
31.00	03100	INTENSIVE CARE UNIT	162,381	68,179	42,670	12,005	843	31.00
40.00	04000	SUBPROVIDER - IPF	295,821	81,993	51,315	164	106	40.00
41.00	04100	SUBPROVIDER - IRF	115,766	26,214	16,406	192	92	41.00
43.00	04300	NURSERY	0	6,869	4,299	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	26,498	16,584	589,415	127,869	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,909	6,828	10,009	468	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	107,187	67,084	25,270	676,391	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	32,303	20,217	869,172	946	59.00
60.00	06000	LABORATORY	0	86,530	0	290,953	55	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,716	16,721	1,706	6,617	65.00
66.00	06600	PHYSICAL THERAPY	0	97,648	0	336	102	66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,951	0	7	273,575	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,277	0	8	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,941,677	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	30,880,590	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	441	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	5,437	3,403	7	17	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	97,419	60,970	4,777	146,122	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	40,269	0	11	7,829	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	4,711	0	55,255	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	26,542	0	38	178,223	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,623,225	1,431,022	542,160	4,809,600	32,304,565	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	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	894,622	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	0	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	4,429	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	353,971	3,048,776	194.04
194.05	07955	OTHER NRCC	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.08	07958	CAMBRIDGE RHC	0	0	0	0	68,852	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		TOTAL (sum lines 118 through 201)	1,623,225	2,330,073	542,160	5,163,571	35,422,193	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS	
				16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP BLDG & FIXT - OFFSITE					1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00540	NONPATIENT TELEPHONES					5.01
5.02 00550	DATA PROCESSING					5.02
5.03 00560	PURCHASING RECEIVING AND STORES					5.03
5.04 00570	ADMINITTING					5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 00590	OTHER A&G					5.06
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	7,953,673				16.00
17.00 01700	SOCIAL SERVICE	0	3,812,980			17.00
17.01 01701	INSERVICE EDUCATION	0	0	4,304,289		17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,890,079	21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	22.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	491,614	22.00
23.00 02300	PARAMED ED PRGM	0	0	28,249		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	505,626	2,697,430	967,899	1,461,474	380,133
31.00 03100	INTENSIVE CARE UNIT	90,286	157,470	242,299	130,689	33,993
40.00 04000	SUBPROVIDER - IPF	101,099	0	205,722	0	0
41.00 04100	SUBPROVIDER - IRF	39,401	0	59,569	0	0
43.00 04300	NURSERY	20,156	0	12,763	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,464,829	0	62,800	87,126	22,662
52.00 05200	DELIVERY ROOM & LABOR ROOM	83,374	169,871	21,060	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,208,716	0	258,166	44,968	11,696
59.00 05900	CARDIAC CATHETERIZATION	909,947	0	63,180	0	0
60.00 06000	LABORATORY	792,032	0	176,776	0	0
65.00 06500	RESPIRATORY THERAPY	255,448	0	86,298	0	0
66.00 06600	PHYSICAL THERAPY	160,095	0	191,914	0	0
69.00 06900	ELECTROCARDIOLOGY	241,055	0	39,935	56,211	14,620
70.00 07000	ELECTROENCEPHALOGRAPHY	35,771	0	7,094	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	357	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	263,883	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	994,033	0	0	0	0
74.00 07400	RENAL DIALYSIS	9,164	0	5,827	0	0
76.00 03950	ANCILLARY - OTHER	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	8,544	0	9,754	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	655,166	788,209	230,550	109,611	28,510
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00 04040	FAMILY PRACTICE	60,432	0	49,499	0	0
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	2,465	0	17,038	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	51,794	0	40,663		
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	7,953,673	3,812,980	2,777,055	1,890,079	491,614
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	RENTAL SPACE	0	0	0	0	0
194.01 07951	FOUNDATION	0	0	1,140	0	0
194.02 07952	RETAIL SERVICES	0	0	2,312	0	0
194.03 07953	REID CONTRACTED SERVICES	0	0	0	0	0
194.04 07954	REID PHYSICIAN ASSOC.	0	0	1,134,127	0	0
194.05 07955	OTHER NRCC	0	0	341,740	0	0
194.06 07956	VACANT SPACE	0	0	0	0	0
194.08 07958	CAMBRIDGE RHC	0	0	47,915	0	0
200.00	Cross Foot Adjustments				0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	7,953,673	3,812,980	4,304,289	1,890,079	491,614

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Prepared: 5/22/2019 7:59 am
Cost Center Description			PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
			23.00	24.00	25.00	26.00
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	NONPATIENT TELEPHONES				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	PURCHASING RECEIVING AND STORES				5.03
5.04	00570	ADMITTING				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06	00590	OTHER A&G				5.06
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
17.01	01701	INSERVICE EDUCATION				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD				22.00
23.00	02300	PARAMED ED PRGM	571,542			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	44,955,722	-1,841,607	30.00
31.00	03100	INTENSIVE CARE UNIT	0	10,431,613	-164,682	31.00
40.00	04000	SUBPROVIDER - I PF	0	7,504,854	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	3,513,816	0	41.00
43.00	04300	NURSERY	0	926,124	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	33,773,792	-109,788	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,604,557	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	571,542	23,665,397	-56,664	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	11,973,816	0	59.00
60.00	06000	LABORATORY	0	15,647,913	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,513,936	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,129,051	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,847,541	-70,831	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	932,791	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	26,481	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	19,068,477	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	33,779,640	0	73.00
74.00	07400	RENAL DIALYSIS	0	994,581	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	492,632	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	13,468,694	-138,121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	3,699,979	0	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	678,065	0	96.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	3,873,360	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	571,542	251,502,832	-2,381,693	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,721,426	0	192.00
194.00	07950	RENTAL SPACE	0	6,124,585	0	194.00
194.01	07951	FOUNDATION	0	643,058	0	194.01
194.02	07952	RETAIL SERVICES	0	744,146	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	275,803	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	145,394,853	0	194.04
194.05	07955	OTHER NRCC	0	357,726	0	194.05
194.06	07956	VACANT SPACE	0	770,859	0	194.06
194.08	07958	CAMBRIDGE RHC	0	1,756,539	0	194.08
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	571,542	411,291,827	-2,381,693	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP		
		0	1.00	1.01		
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP BLDG & FIXT - OFFSITE					1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	8,517	42,398	9,531	0	4.00
5.01 00540	NONPATIENT TELEPHONES	244	60,332	0	0	5.01
5.02 00550	DATA PROCESSING	4,126,910	198,851	26,092	0	5.02
5.03 00560	PURCHASING RECEIVING AND STORES	15,583	248,603	0	0	5.03
5.04 00570	ADMITTING	16,162	2,287	44,892	0	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	85,258	12,946	194,436	0	5.05
5.06 00590	OTHER A&G	66,182	398,528	168,106	0	5.06
7.00 00700	OPERATION OF PLANT	141,452	2,893,778	99,076	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	76,232	195,944	0	0	8.00
9.00 00900	HOUSEKEEPING	33,791	107,638	0	0	9.00
10.00 01000	DIETARY	132,670	199,645	0	0	10.00
11.00 01100	CAFETERIA	0	156,835	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	31,056	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	454,073	133,610	0	0	14.00
15.00 01500	PHARMACY	298,734	115,501	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	39,263	55,709	140,179	0	16.00
17.00 01700	SOCIAL SERVICE	2,252	19,714	0	0	17.00
17.01 01701	INSERVICE EDUCATION	28,168	165,349	0	0	17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	35,736	0	0	0	22.00
23.00 02300	PARAMED ED PRGM	1,181	16,854	63,859	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	470,554	1,735,394	0	0	30.00
31.00 03100	INTENSIVE CARE UNIT	429,276	390,013	0	0	31.00
40.00 04000	SUBPROVIDER - I/PF	36,243	354,875	0	0	40.00
41.00 04100	SUBPROVIDER - I/RF	43,456	284,313	0	0	41.00
43.00 04300	NURSERY	7,557	42,588	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	861,186	769,892	311,931	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	43,328	132,101	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,129,930	965,502	38,125	0	54.00
59.00 05900	CARDIAC CATHETERIZATION	276,169	215,705	0	0	59.00
60.00 06000	LABORATORY	408,260	221,519	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	45,989	26,163	0	0	65.00
66.00 06600	PHYSICAL THERAPY	102,283	128,416	1,008,301	0	66.00
69.00 06900	ELECTROCARDIOLOGY	105,906	111,371	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	5,148	0	92,738	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	6,425	23,669	0	0	74.00
76.00 03950	ANCILLARY - OTHER	0	0	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	10,524	71,849	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	195,880	361,738	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	24,480	141,934	20,182	0	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	148	28,180	68,434	0	96.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00 11600	HOSPICE	4,485	7,069	0	0	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	9,769,635	11,067,869	2,285,882	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	115,293	3,955	58,521	0	192.00
194.00 07950	RENTAL SPACE	120,395	0	453,445	0	194.00
194.01 07951	FOUNDATION	929	3,272	0	0	194.01
194.02 07952	RETAIL SERVICES	410	37,171	0	0	194.02
194.03 07953	REID CONTRACTED SERVICES	0	0	0	0	194.03
194.04 07954	REID PHYSICIAN ASSOC.	1,316,740	547,865	3,356,609	0	194.04
194.05 07955	OTHER NRCC	0	8,451	0	0	194.05
194.06 07956	VACANT SPACE	0	22,001	409,077	0	194.06
194.08 07958	CAMBRI DGE RHC	27,882	0	0	0	194.08
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP		
202.00	TOTAL (sum lines 118 through 201)	11,351,284	11,690,584	6,563,534	0	29,605,402	202.00

Provider CCN: 15-0048

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

Worksheet B
Part II
Date/Time Prepared:
5/22/2019 7:59 am

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0048		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part II Date/Time Prepared: 5/22/2019 7:59 am	
Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	
			4.00	5.01	5.02	5.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	60,446					4.00
5.01	00540	NONPATIENT TELEPHONES	94	60,670				5.01
5.02	00550	DATA PROCESSING	1,436	6,388	4,359,677			5.02
5.03	00560	PURCHASING RECEIVING AND STORES	317	848	454,491	719,842		5.03
5.04	00570	ADMINISTRATIVE	758	2,385	66,837	943	134,264	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,195	3,737	28,644	1,609	0	5.05
5.06	00590	OTHER A&G	3,552	3,128	53,470	6,419	0	5.06
7.00	00700	OPERATION OF PLANT	956	1,537	0	6,793	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	119	159	3,819	131	0	8.00
9.00	00900	HOUSEKEEPING	589	159	5,729	12,667	0	9.00
10.00	01000	DIETARY	173	2,332	64,927	9,947	0	10.00
11.00	01100	CAFETERIA	764	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	75	477	26,735	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	202	265	22,916	83,039	0	14.00
15.00	01500	PHARMACY	1,356	1,140	76,385	64,913	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,278	1,802	160,409	1,682	0	16.00
17.00	01700	SOCIAL SERVICE	750	901	53,470	809	0	17.00
17.01	01701	INSERVICE EDUCATION	385	1,219	282,625	1,662	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	487	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	64	0	0	205	0	22.00
23.00	02300	PARAMED ED PRGM	74	80	19,096	147	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,406	6,043	454,491	59,499	8,535	30.00
31.00	03100	INTENSIVE CARE UNIT	1,327	1,378	66,837	28,387	1,524	31.00
40.00	04000	SUBPROVIDER - IPF	1,305	583	28,644	7,085	1,707	40.00
41.00	04100	SUBPROVIDER - IRF	461	848	53,470	4,604	665	41.00
43.00	04300	NURSERY	161	0	0	5,697	340	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	421	5,009	166,137	101,648	24,727	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	256	1,140	61,108	8,853	1,407	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,000	4,055	290,263	71,660	20,404	54.00
59.00	05900	CARDIAC CATHETERIZATION	630	769	19,096	54,357	15,361	59.00
60.00	06000	LABORATORY	1,211	1,696	110,758	8,733	13,370	60.00
65.00	06500	RESPIRATORY THERAPY	454	159	22,916	24,605	4,312	65.00
66.00	06600	PHYSICAL THERAPY	1,838	2,385	198,601	3,331	2,703	66.00
69.00	06900	ELECTROCARDIOLOGY	286	239	93,572	9,436	4,069	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	117	186	15,277	1,313	604	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	6	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,455	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	16,780	73.00
74.00	07400	RENAL DIALYSIS	0	133	3,819	1,478	155	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	76	318	3,819	777	144	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,718	2,173	143,222	29,260	11,060	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	616	1,511	74,475	5,228	1,020	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	48	663	22,916	7,208	42	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	446	345	5,729	11,500	874	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,401	56,190	3,154,703	635,625	134,264	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	1,723	1,910	713	0	192.00
194.00	07950	RENTAL SPACE	0	2,571	0	9,829	0	194.00
194.01	07951	FOUNDATION	62	186	11,458	677	0	194.01
194.02	07952	RETAIL SERVICES	43	0	68,747	233	0	194.02
194.03	07953	REID CONTRACTED SERVICES	38	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	25,543	0	1,122,859	71,331	0	194.04
194.05	07955	OTHER NRCC	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.08	07958	CAMBRIDGE RHC	359	0	0	1,434	0	194.08
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)	60,446	60,670	4,359,677	719,842	134,264	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/22/2019 7:59 am		
Cost Center Description			CASHIERING/AC COUNTS RECEIVABLE	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			5.05	5.06	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	327,825				5.05
5.06	00590	OTHER A&G	0	699,385			5.06
7.00	00700	OPERATION OF PLANT	0	13,564	3,157,156		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,724	62,704	340,832	8.00
9.00	00900	HOUSEKEEPING	0	5,214	32,992	0	198,779
10.00	01000	DIETARY	0	2,397	56,096	0	4,537
11.00	01100	CAFETERIA	0	3,747	50,189	0	0
13.00	01300	NURSING ADMINISTRATION	0	871	9,938	0	238
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,552	42,757	0	298
15.00	01500	PHARMACY	0	59,966	35,787	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,295	5,907	0	744
17.00	01700	SOCIAL SERVICE	0	6,380	2,227	0	1,131
17.01	01701	INSERVICE EDUCATION	0	7,001	47,388	0	2,826
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	3,184	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	829	0	0	0
23.00	02300	PARAMED ED PRGM	0	825	14,269	0	1,205
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	20,841	58,623	549,724	101,111	67,147
31.00	03100	INTENSIVE CARE UNIT	3,721	15,122	124,809	22,604	12,986
40.00	04000	SUBPROVIDER - IPF	4,167	10,610	113,564	18,622	11,290
41.00	04100	SUBPROVIDER - IRF	1,624	4,916	90,984	9,508	6,486
43.00	04300	NURSERY	831	1,436	13,629	0	208
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	60,367	51,679	206,510	55,016	17,493
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,436	3,552	42,274	17,953	2,841
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,821	33,809	223,265	34,918	8,196
59.00	05900	CARDIAC CATHETERIZATION	37,506	16,860	23,348	19,570	2,395
60.00	06000	LABORATORY	32,646	23,805	69,003	0	8,167
65.00	06500	RESPIRATORY THERAPY	10,529	5,233	6,070	0	1,785
66.00	06600	PHYSICAL THERAPY	6,599	18,757	245,124	2,391	1,398
69.00	06900	ELECTROCARDIOLOGY	9,936	5,359	2,831	0	3,020
70.00	07000	ELECTROENCEPHALOGRAPHY	1,474	1,375	27,451	1,422	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15	1	0	0	1,607
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,877	26,977	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	40,972	3,180	0	0	2,231
74.00	07400	RENAL DIALYSIS	378	1,565	7,574	0	2,499
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	352	772	0	0	744
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	27,005	18,097	115,760	47,747	15,723
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00	04040	FAMILY PRACTICE	2,491	5,864	2,059	9,970	3,421
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	102	936	19,073	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	2,135	6,028	0	0	2,008
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	327,825	442,105	2,243,306	340,832	182,624
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,275	12,485	0	0
194.00	07950	RENTAL SPACE	0	8,405	113,971	0	0
194.01	07951	FOUNDATION	0	1,084	1,047	0	119
194.02	07952	RETAIL SERVICES	0	1,243	3,477	0	149
194.03	07953	REID CONTRACTED SERVICES	0	462	0	0	0
194.04	07954	REID PHYSICIAN ASSOC.	0	236,212	659,851	0	15,887
194.05	07955	OTHER NRCC	0	16	2,704	0	0
194.06	07956	VACANT SPACE	0	794	120,315	0	0
194.08	07958	CAMBRIDGE RHC	0	2,789	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	327,825	699,385	3,157,156	340,832	198,779

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0048		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part II Date/Time Prepared: 5/22/2019 7:59 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
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	472,724					10.00
11.00	01100	CAFETERIA	0	211,535				11.00
13.00	01300	NURSING ADMINISTRATION	0	111	69,501			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,989	0	747,701		14.00
15.00	01500	PHARMACY	0	6,172	0	383	660,337	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,927	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,418	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	0	2,078	0	2	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,603	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	367	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	283	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	305,569	34,184	30,211	861	80	30.00
31.00	03100	INTENSIVE CARE UNIT	47,290	6,190	5,470	1,738	16	31.00
40.00	04000	SUBPROVIDER - IPF	86,151	7,444	6,578	24	2	40.00
41.00	04100	SUBPROVIDER - IRF	33,714	2,380	2,103	28	2	41.00
43.00	04300	NURSERY	0	624	551	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,406	2,126	85,348	2,384	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	990	875	1,449	9	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,731	8,600	3,659	12,609	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,933	2,592	125,857	18	59.00
60.00	06000	LABORATORY	0	7,856	0	42,130	1	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,425	2,143	247	123	65.00
66.00	06600	PHYSICAL THERAPY	0	8,865	0	49	2	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,448	0	1	5,100	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	661	0	1	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	425,968	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	575,672	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	8	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	494	436	1	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	8,844	7,816	692	2,724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	3,656	0	2	146	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	428	0	8,001	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,410	0	5	3,322	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	472,724	129,917	69,501	696,446	602,218	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	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	81,216	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	0	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	402	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	51,255	56,835	194.04
194.05	07955	OTHER NRCC	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.08	07958	CAMBRIDGE RHC	0	0	0	0	1,284	194.08
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)	472,724	211,535	69,501	747,701	660,337	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS	
				16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP BLDG & FIXT - OFFSITE					1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00540	NONPATIENT TELEPHONES					5.01
5.02 00550	DATA PROCESSING					5.02
5.03 00560	PURCHASING RECEIVING AND STORES					5.03
5.04 00570	ADMINISTRATIVE					5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 00590	OTHER A&G					5.06
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	430,195				16.00
17.00 01700	SOCIAL SERVICE	0	91,052			17.00
17.01 01701	INSERVICE EDUCATION	0	0	538,703		17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	5,274	21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM	0	0	3,535		23.00
23.00 02300	PARAMED ED PRGM	0	0	3,535		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	27,334	64,414	121,137		30.00
31.00 03100	INTENSIVE CARE UNIT	4,881	3,760	30,325		31.00
40.00 04000	SUBPROVIDER - I/PF	5,465	0	25,747		40.00
41.00 04100	SUBPROVIDER - I/RF	2,130	0	7,455		41.00
43.00 04300	NURSERY	1,090	0	1,597		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	79,412	0	7,860		50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,507	4,056	2,636		52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	65,343	0	32,311		54.00
59.00 05900	CARDIAC CATHETERIZATION	49,191	0	7,907		59.00
60.00 06000	LABORATORY	42,817	0	22,124		60.00
65.00 06500	RESPIRATORY THERAPY	13,809	0	10,801		65.00
66.00 06600	PHYSICAL THERAPY	8,655	0	24,019		66.00
69.00 06900	ELECTROCARDIOLOGY	13,031	0	4,998		69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,934	0	888		70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19	0	0		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	14,265	0	0		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	53,737	0	0		73.00
74.00 07400	RENAL DIALYSIS	495	0	729		74.00
76.00 03950	ANCILLARY - OTHER	0	0	0		76.00
76.97 07697	CARDIAC REHABILITATION	462	0	1,221		76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	35,418	18,822	28,854		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00 04040	FAMILY PRACTICE	3,267	0	6,195		93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	133	0	2,132		96.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	2,800	0	5,089		116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	430,195	91,052	347,560	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00 07950	RENTAL SPACE	0	0	0		194.00
194.01 07951	FOUNDATION	0	0	143		194.01
194.02 07952	RETAIL SERVICES	0	0	289		194.02
194.03 07953	REID CONTRACTED SERVICES	0	0	0		194.03
194.04 07954	REID PHYSICIAN ASSOC.	0	0	141,944		194.04
194.05 07955	OTHER NRCC	0	0	42,770		194.05
194.06 07956	VACANT SPACE	0	0	0		194.06
194.08 07958	CAMBRIDGE RHC	0	0	5,997		194.08
200.00	Cross Foot Adjustments				5,274	37,201
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	430,195	91,052	538,703	5,274	37,201

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/22/2019 7:59 am
Cost Center Description			PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
			23.00	24.00	25.00	26.00
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	NONPATIENT TELEPHONES				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	PURCHASING RECEIVING AND STORES				5.03
5.04	00570	ADMITTING				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06	00590	OTHER A&G				5.06
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
17.01	01701	INSERVICE EDUCATION				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD				22.00
23.00	02300	PARAMED PRGM	121,408			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,122,158	0	4,122,158
31.00	03100	INTENSIVE CARE UNIT		1,197,654	0	1,197,654
40.00	04000	SUBPROVIDER - I PF		720,106	0	720,106
41.00	04100	SUBPROVIDER - IRF		549,147	0	549,147
43.00	04300	NURSERY		76,309	0	76,309
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		2,811,552	0	2,811,552
52.00	05200	DELIVERY ROOM & LABOR ROOM		332,771	0	332,771
54.00	05400	RADIOLOGY-DIAGNOSTIC		3,004,201	0	3,004,201
59.00	05900	CARDIAC CATHETERIZATION		870,264	0	870,264
60.00	06000	LABORATORY		1,014,096	0	1,014,096
65.00	06500	RESPIRATORY THERAPY		177,763	0	177,763
66.00	06600	PHYSICAL THERAPY		1,763,717	0	1,763,717
69.00	06900	ELECTROCARDIOLOGY		370,603	0	370,603
70.00	07000	ELECTROENCEPHALOGRAPHY		150,589	0	150,589
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,648	0	1,648
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		482,542	0	482,542
73.00	07300	DRUGS CHARGED TO PATIENTS		692,572	0	692,572
74.00	07400	RENAL DIALYSIS		48,927	0	48,927
76.00	03950	ANCILLARY - OTHER		0	0	0
76.97	07697	CARDIAC REHABILITATION		91,989	0	91,989
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY		1,072,553	0	1,072,553
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	
93.00	04040	FAMILY PRACTICE		306,517	0	306,517
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		158,444	0	158,444
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE		54,245	0	54,245
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	20,070,367	0	20,070,367
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES		200,875	0	200,875
194.00	07950	RENTAL SPACE		789,832	0	789,832
194.01	07951	FOUNDATION		18,977	0	18,977
194.02	07952	RETAIL SERVICES		111,762	0	111,762
194.03	07953	REID CONTRACTED SERVICES		902	0	902
194.04	07954	REID PHYSICIAN ASSOC.		7,602,931	0	7,602,931
194.05	07955	OTHER NRCC		53,941	0	53,941
194.06	07956	VACANT SPACE		552,187	0	552,187
194.08	07958	CAMBRIDGE RHC		39,745	0	39,745
200.00		Cross Foot Adjustments	121,408	163,883	0	163,883
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	121,408	29,605,402	0	29,605,402

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0048

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

Worksheet B-1
Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	735,942				1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	0	275,456			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,669	400	0	174,653,329	4.00
5.01	00540	NONPATIENT TELEPHONES	3,798	0	0	272,496	2,289
5.02	00550	DATA PROCESSING	12,518	1,095	0	4,150,904	241
5.03	00560	PURCHASING RECEIVING AND STORES	15,650	0	0	915,645	32
5.04	00570	ADMITTING	144	1,884	0	2,191,235	90
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	815	8,160	0	3,452,939	141
5.06	00590	OTHER A&G	25,088	7,055	0	10,266,243	118
7.00	00700	OPERATION OF PLANT	182,168	4,158	0	2,764,407	58
8.00	00800	LAUNDRY & LINEN SERVICE	12,335	0	0	344,470	6
9.00	00900	HOUSEKEEPING	6,776	0	0	1,701,755	6
10.00	01000	DIETARY	12,568	0	0	498,698	88
11.00	01100	CAFETERIA	9,873	0	0	2,209,253	0
13.00	01300	NURSING ADMINISTRATION	1,955	0	0	216,509	18
14.00	01400	CENTRAL SERVICES & SUPPLY	8,411	0	0	582,994	10
15.00	01500	PHARMACY	7,271	0	0	3,919,906	43
16.00	01600	MEDICAL RECORDS & LIBRARY	3,507	5,883	0	3,692,237	68
17.00	01700	SOCIAL SERVICE	1,241	0	0	2,167,073	34
17.01	01701	INSERVICE EDUCATION	10,409	0	0	1,111,773	46
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,408,751	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	184,203	0
23.00	02300	PARAMED PRGM	1,061	2,680	0	213,753	3
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	109,246	0	0	18,515,598	228
31.00	03100	INTENSIVE CARE UNIT	24,552	0	0	3,835,104	52
40.00	04000	SUBPROVIDER - I PF	22,340	0	0	3,772,749	22
41.00	04100	SUBPROVIDER - I RF	17,898	0	0	1,333,508	32
43.00	04300	NURSERY	2,681	0	0	465,815	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	48,466	13,091	0	1,216,095	189
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,316	0	0	738,699	43
54.00	05400	RADIOLOGY-DIAGNOSTIC	60,780	1,600	0	5,779,910	153
59.00	05900	CARDIAC CATHETERIZATION	13,579	0	0	1,821,955	29
60.00	06000	LABORATORY	13,945	0	0	3,499,030	64
65.00	06500	RESPIRATORY THERAPY	1,647	0	0	1,313,520	6
66.00	06600	PHYSICAL THERAPY	8,084	42,316	0	5,313,451	90
69.00	06900	ELECTROCARDIOLOGY	7,011	0	0	825,995	9
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,892	0	338,343	7
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	1,490	0	0	0	5
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	4,523	0	0	218,763	12
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	22,772	0	0	4,966,118	82
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00	04040	FAMILY PRACTICE	8,935	847	0	1,780,855	57
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,774	2,872	0	137,979	25
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	445	0	0	1,290,242	13
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	696,741	95,933	0	99,428,973	2,120
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	249	2,456	0	0	65
194.00	07950	RENTAL SPACE	0	19,030	0	0	97
194.01	07951	FOUNDATION	206	0	0	179,848	7
194.02	07952	RETAIL SERVICES	2,340	0	0	124,379	0
194.03	07953	REID CONTRACTED SERVICES	0	0	0	109,540	0
194.04	07954	REID PHYSICIAN ASSOC.	34,489	140,869	0	73,773,732	0
194.05	07955	OTHER NRCC	532	0	0	0	0
194.06	07956	VACANT SPACE	1,385	17,168	0	0	0
194.08	07958	CAMBRI DGE RHC	0	0	0	1,036,857	0
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0048

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

Worksheet B-1

Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00			
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	11,690,584	6,563,534	0	31,034,369	403,546	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	15.885197	23.827885	0.000000	0.177691	176.297947	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				60,446	60,670	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000346	26.505024	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: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet B-1 Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description		DATA PROCESSING (TERMINALS)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMITTING (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	
		5.02	5.03	5.04	5.05	5A.06	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING	2,283				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	238	8,862,413			5.03
5.04	00570	ADMITTING	35	11,605	823,670,284		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	15	19,809	0	823,670,284	5.05
5.06	00590	OTHER A&G	28	79,023	0	0	-31,565,409
7.00	00700	OPERATION OF PLANT	0	83,627	0	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	2	1,609	0	0	0
9.00	00900	HOUSEKEEPING	3	155,956	0	0	0
10.00	01000	DIETARY	34	122,458	0	0	0
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	14	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	12	1,022,343	0	0	0
15.00	01500	PHARMACY	40	799,187	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	84	20,712	0	0	0
17.00	01700	SOCIAL SERVICE	28	9,957	0	0	0
17.01	01701	INSERVICE EDUCATION	148	20,463	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	2,522	0	0	0
23.00	02300	PARAMED PRGM	10	1,813	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	238	732,525	52,363,887	52,363,887	0
31.00	03100	INTENSIVE CARE UNIT	35	349,493	9,350,237	9,350,237	0
40.00	04000	SUBPROVIDER - I PF	15	87,233	10,470,112	10,470,112	0
41.00	04100	SUBPROVIDER - I RF	28	56,682	4,080,441	4,080,441	0
43.00	04300	NURSERY	0	70,144	2,087,423	2,087,423	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	87	1,251,422	151,669,006	151,669,006	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	32	108,990	8,634,375	8,634,375	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	152	882,248	125,177,677	125,177,677	0
59.00	05900	CARDIAC CATHETERIZATION	10	669,227	94,236,463	94,236,463	0
60.00	06000	LABORATORY	58	107,517	82,024,877	82,024,877	0
65.00	06500	RESPIRATORY THERAPY	12	302,933	26,454,860	26,454,860	0
66.00	06600	PHYSICAL THERAPY	104	41,006	16,579,833	16,579,833	0
69.00	06900	ELECTROCARDIOLOGY	49	116,175	24,964,279	24,964,279	0
70.00	07000	ELECTROENCEPHALOGRAPHY	8	16,169	3,704,586	3,704,586	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	37,010	37,010	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	27,328,422	27,328,422	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	102,944,551	102,944,551	0
74.00	07400	RENAL DIALYSIS	2	18,200	949,063	949,063	0
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	2	9,569	884,812	884,812	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	75	360,242	67,850,634	67,850,634	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
93.00	04040	FAMILY PRACTICE	39	64,369	6,258,529	6,258,529	0
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	12	88,745	255,265	255,265	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	3	141,589	5,363,942	5,363,942	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,652	7,825,562	823,670,284	823,670,284	-31,565,409
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1	8,780	0	0	0
194.00	07950	RENTAL SPACE	0	121,012	0	0	0
194.01	07951	FOUNDATION	6	8,332	0	0	0
194.02	07952	RETAIL SERVICES	36	2,868	0	0	0
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0
194.04	07954	REID PHYSICIAN ASSOC.	588	878,206	0	0	0
194.05	07955	OTHER NRCC	0	0	0	0	0
194.06	07956	VACANT SPACE	0	0	0	0	0
194.08	07958	CAMBRIDGE RHC	0	17,653	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0048

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

Worksheet B-1
Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Description		DATA PROCESSING (TERMINALS)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMINISTRATIVE (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	
		5.02	5.03	5.04	5.05	5A.06	
202.00	Cost to be allocated (per Wkst. B, Part I)	29,932,532	4,889,105	4,281,160	9,529,967		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	13,111.052124	0.551667	0.005198	0.011570		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	4,359,677	719,842	134,264	327,825		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1,909.626369	0.081224	0.000163	0.000398		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: 15-0048		Period: From 01/01/2018 To 12/31/2018		Worksheet B-1	
Date/Time Prepared: 5/22/2019 7:59 am							
Cost Center	Description	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590	379,726,418					5.06
7.00	00700	7,363,686	621,066				7.00
8.00	00800	936,150	12,335	1,891,761			8.00
9.00	00900	2,830,619	6,490	0	13,363		9.00
10.00	01000	1,301,447	11,035	0	305	52,441	10.00
11.00	01100	2,034,187	9,873	0	0	0	11.00
13.00	01300	472,765	1,955	0	16	0	13.00
14.00	01400	4,642,982	8,411	0	20	0	14.00
15.00	01500	32,554,958	7,040	0	0	0	15.00
16.00	01600	7,217,634	1,162	0	50	0	16.00
17.00	01700	3,463,853	438	0	76	0	17.00
17.01	01701	3,800,937	9,322	0	190	0	17.01
21.00	02100	1,728,719	0	0	0	0	21.00
22.00	02200	450,149	0	0	0	0	22.00
23.00	02300	447,811	2,807	0	81	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	31,825,544	108,140	561,216	4,514	33,898	30.00
31.00	03100	8,209,570	24,552	125,460	873	5,246	31.00
40.00	04000	5,760,001	22,340	103,358	759	9,557	40.00
41.00	04100	2,669,004	17,898	52,774	436	3,740	41.00
43.00	04300	779,510	2,681	0	14	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	28,055,732	40,624	305,361	1,176	0	50.00
52.00	05200	1,928,192	8,316	99,646	191	0	52.00
54.00	05400	18,354,623	43,920	193,809	551	0	54.00
59.00	05900	9,152,952	4,593	108,620	161	0	59.00
60.00	06000	12,923,568	13,574	0	549	0	60.00
65.00	06500	2,840,680	1,194	0	120	0	65.00
66.00	06600	10,182,861	48,220	13,271	94	0	66.00
69.00	06900	2,909,348	557	0	203	0	69.00
70.00	07000	746,360	5,400	7,892	0	0	70.00
71.00	07100	620	0	0	108	0	71.00
72.00	07200	14,645,482	0	0	0	0	72.00
73.00	07300	1,726,174	0	0	150	0	73.00
74.00	07400	849,781	1,490	0	168	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.97	07697	418,867	0	0	50	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	9,824,866	22,772	265,015	1,057	0	91.00
92.00	09200						92.00
93.00	04040	3,183,596	405	55,339	230	0	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	508,169	3,752	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	3,272,270	0	0	135	0	116.00
118.00		240,013,667	441,296	1,891,761	12,277	52,441	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	3,406,697	2,456	0	0	0	192.00
194.00	07950	4,562,755	22,420	0	0	0	194.00
194.01	07951	588,470	206	0	8	0	194.01
194.02	07952	674,614	684	0	10	0	194.02
194.03	07953	250,547	0	0	0	0	194.03
194.04	07954	128,276,215	129,804	0	1,068	0	194.04
194.05	07955	8,451	532	0	0	0	194.05
194.06	07956	431,078	23,668	0	0	0	194.06
194.08	07958	1,513,924	0	0	0	0	194.08
200.00							200.00
201.00							201.00
202.00		31,565,409	7,975,807	1,172,377	3,149,265	1,623,225	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0048

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

Worksheet B-1

Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Description		OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.06	7.00	8.00	9.00	10.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.083127	12.842125	0.619728	235.670508	30.953357	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	699,385	3,157,156	340,832	198,779	472,724	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.001842	5.083447	0.180167	14.875327	9.014397	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: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet B-1 Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description		CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (MED SUPPLIES)	PHARMACY (DRUGS)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	3,980,244					11.00
13.00	01300	2,080	1,479,766				13.00
14.00	01400	37,417	0	20,033,021			14.00
15.00	01500	116,136	0	10,254	28,536,423		15.00
16.00	01600	186,796	0	0	0	823,670,284	16.00
17.00	01700	64,315	0	0	0	0	17.00
17.01	01701	39,100	0	42	0	0	17.01
21.00	02100	30,162	0	0	0	0	21.00
22.00	02200	6,910	0	0	0	0	22.00
23.00	02300	5,330	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	643,217	643,217	23,060	3,447	52,363,887	30.00
31.00	03100	116,464	116,464	46,575	679	9,350,237	31.00
40.00	04000	140,060	140,060	637	85	10,470,112	40.00
41.00	04100	44,779	44,779	745	74	4,080,441	41.00
43.00	04300	11,733	11,733	0	0	2,087,423	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	45,264	45,264	2,286,744	103,012	151,669,006	50.00
52.00	05200	18,635	18,635	38,831	377	8,634,375	52.00
54.00	05400	183,098	183,098	98,039	544,906	125,177,677	54.00
59.00	05900	55,180	55,180	3,372,114	762	94,236,463	59.00
60.00	06000	147,811	0	1,128,804	44	82,024,877	60.00
65.00	06500	45,637	45,637	6,619	5,331	26,454,860	65.00
66.00	06600	166,802	0	1,302	82	16,579,833	66.00
69.00	06900	27,248	0	26	220,394	24,964,279	69.00
70.00	07000	12,431	0	32	0	3,704,586	70.00
71.00	07100	0	0	0	0	37,010	71.00
72.00	07200	0	0	11,412,784	0	27,328,422	72.00
73.00	07300	0	0	0	24,877,672	102,944,551	73.00
74.00	07400	0	0	0	355	949,063	74.00
76.00	03950	0	0	0	0	0	76.00
76.97	07697	9,288	9,288	26	14	884,812	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	166,411	166,411	18,535	117,717	67,850,634	91.00
92.00	09200						92.00
93.00	04040	68,787	0	41	6,307	6,258,529	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	8,048	0	214,370	0	255,265	96.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	45,339	0	147	143,578	5,363,942	116.00
118.00		2,444,478	1,479,766	18,659,727	26,024,836	823,670,284	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	1,528,200	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	7,566	0	0	0	0	194.03
194.04	07954	0	0	1,373,294	2,456,119	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.08	07958	0	0	0	55,468	0	194.08
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0048

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

Worksheet B-1

Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Description		CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (MED SUPPLIES)	PHARMACY (DRUGS)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	2,330,073	542,160	5,163,571	35,422,193	7,953,673	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.585410	0.366382	0.257753	1.241298	0.009656	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	211,535	69,501	747,701	660,337	430,195	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.053146	0.046968	0.037323	0.023140	0.000522	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: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet B-1 Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INSERVICE EDUCATION (IN HOUSE ED)	INTERNS & RESIDENTS		PARAMED PRGM (TIME SPENT)	
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
			17.00	17.01		
GENERAL SERVICE COST CENTERS						
1.00 00100						1.00
1.01 00101						1.01
2.00 00200						2.00
4.00 00400						4.00
5.01 00540						5.01
5.02 00550						5.02
5.03 00560						5.03
5.04 00570						5.04
5.05 00580						5.05
5.06 00590						5.06
7.00 00700						7.00
8.00 00800						8.00
9.00 00900						9.00
10.00 01000						10.00
11.00 01100						11.00
13.00 01300						13.00
14.00 01400						14.00
15.00 01500						15.00
16.00 01600						16.00
17.00 01700	48,888					17.00
17.01 01701	0	135,915				17.01
21.00 02100	0	0	1,345			21.00
22.00 02200	0	0		1,345		22.00
23.00 02300	0	892			100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	34,585	30,563	1,040	1,040	0	30.00
31.00 03100	2,019	7,651	93	93	0	31.00
40.00 04000	0	6,496	0	0	0	40.00
41.00 04100	0	1,881	0	0	0	41.00
43.00 04300	0	403	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	0	1,983	62	62	0	50.00
52.00 05200	2,178	665	0	0	0	52.00
54.00 05400	0	8,152	32	32	100	54.00
59.00 05900	0	1,995	0	0	0	59.00
60.00 06000	0	5,582	0	0	0	60.00
65.00 06500	0	2,725	0	0	0	65.00
66.00 06600	0	6,060	0	0	0	66.00
69.00 06900	0	1,261	40	40	0	69.00
70.00 07000	0	224	0	0	0	70.00
71.00 07100	0	0	0	0	0	71.00
72.00 07200	0	0	0	0	0	72.00
73.00 07300	0	0	0	0	0	73.00
74.00 07400	0	184	0	0	0	74.00
76.00 03950	0	0	0	0	0	76.00
76.97 07697	0	308	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	10,106	7,280	78	78	0	91.00
92.00 09200						92.00
93.00 04040	0	1,563	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	0	538	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300						113.00
116.00 11600	0	1,284			0	116.00
118.00	48,888	87,690	1,345	1,345	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	0	0	0	0	0	190.00
192.00 19200	0	0	0	0	0	192.00
194.00 07950	0	0	0	0	0	194.00
194.01 07951	0	36	0	0	0	194.01
194.02 07952	0	73	0	0	0	194.02
194.03 07953	0	0	0	0	0	194.03
194.04 07954	0	35,812	0	0	0	194.04
194.05 07955	0	10,791	0	0	0	194.05
194.06 07956	0	0	0	0	0	194.06
194.08 07958	0	1,513	0	0	0	194.08
200.00						200.00
201.00						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0048

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

Worksheet B-1

Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INSERVICE EDUCATION (IN HOUSE ED)	INTERNS & RESIDENTS		PARAMED PRGM (TIME SPENT)	
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
			17.00	17.01		
202.00 Cost to be allocated (per Wkst. B, Part I)	3,812,980	4,304,289	1,890,079	491,614	571,542	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	77.994191	31.668977	1,405.263197	365.512268	5,715.420000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	91,052	538,703	5,274	37,201	121,408	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	1.862461	3.963529	3.921190	27.658736	1,214.080000	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0048

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

Worksheet C
Part I
Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	Hospital			
					RCE Disallowance	Total Costs		PPS
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,114,115		43,114,115	0	43,114,115	30.00
31.00	03100	INTENSIVE CARE UNIT	10,266,931		10,266,931	0	10,266,931	31.00
40.00	04000	SUBPROVIDER - IPF	7,504,854		7,504,854	0	7,504,854	40.00
41.00	04100	SUBPROVIDER - IRF	3,513,816		3,513,816	0	3,513,816	41.00
43.00	04300	NURSERY	926,124		926,124	0	926,124	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,664,004		33,664,004	0	33,664,004	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,604,557		2,604,557	0	2,604,557	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,608,733		23,608,733	0	23,608,733	54.00
59.00	05900	CARDIAC CATHETERIZATION	11,973,816		11,973,816	0	11,973,816	59.00
60.00	06000	LABORATORY	15,647,913		15,647,913	0	15,647,913	60.00
65.00	06500	RESPIRATORY THERAPY	3,513,936	0	3,513,936	0	3,513,936	65.00
66.00	06600	PHYSICAL THERAPY	12,129,051	0	12,129,051	0	12,129,051	66.00
69.00	06900	ELECTROCARDIOLOGY	3,776,710		3,776,710	0	3,776,710	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	932,791		932,791	0	932,791	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,481		26,481	0	26,481	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,068,477		19,068,477	0	19,068,477	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,779,640		33,779,640	0	33,779,640	73.00
74.00	07400	RENAL DIALYSIS	994,581		994,581	0	994,581	74.00
76.00	03950	ANCILLARY - OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	492,632		492,632	0	492,632	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	13,330,573		13,330,573	0	13,330,573	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,448,444		4,448,444	0	4,448,444	92.00
93.00	04040	FAMILY PRACTICE	3,699,979		3,699,979	0	3,699,979	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	678,065		678,065	0	678,065	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,873,360		3,873,360		3,873,360	116.00
200.00		Subtotal (see instructions)	253,569,583	0	253,569,583	0	253,569,583	200.00
201.00		Less Observation Beds	4,448,444		4,448,444		4,448,444	201.00
202.00		Total (see instructions)	249,121,139	0	249,121,139	0	249,121,139	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/22/2019 7:59 am
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,151,769		45,151,769	30.00
31.00	03100	INTENSIVE CARE UNIT	9,350,237		9,350,237	31.00
40.00	04000	SUBPROVIDER - IPF	10,470,112		10,470,112	40.00
41.00	04100	SUBPROVIDER - IRF	4,080,441		4,080,441	41.00
43.00	04300	NURSERY	2,087,423		2,087,423	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,670,875	96,998,131	151,669,006	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,705,907	928,468	8,634,375	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,002,655	96,175,022	125,177,677	54.00
59.00	05900	CARDIAC CATHETERIZATION	36,838,482	57,397,981	94,236,463	59.00
60.00	06000	LABORATORY	32,839,660	49,185,217	82,024,877	60.00
65.00	06500	RESPIRATORY THERAPY	23,610,522	2,844,338	26,454,860	65.00
66.00	06600	PHYSICAL THERAPY	6,820,693	9,759,140	16,579,833	66.00
69.00	06900	ELECTROCARDIOLOGY	5,357,055	19,607,224	24,964,279	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38,955	3,665,631	3,704,586	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,875	135	37,010	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,163,965	10,164,457	27,328,422	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,999,139	57,945,412	102,944,551	73.00
74.00	07400	RENAL DIALYSIS	890,101	58,962	949,063	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	6,362	878,450	884,812	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	15,467,468	52,383,166	67,850,634	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,924,453	5,287,665	7,212,118	92.00
93.00	04040	FAMILY PRACTICE	12,868	6,245,661	6,258,529	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	255,265	255,265	96.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	1,265,305	4,098,637	5,363,942	116.00
200.00		Subtotal (see instructions)	349,791,322	473,878,962	823,670,284	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	349,791,322	473,878,962	823,670,284	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/22/2019 7:59 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.221957		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.301650		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.188602		54.00
59.00	05900 CARDIAC CATHETERIZATION	0.127061		59.00
60.00	06000 LABORATORY	0.190770		60.00
65.00	06500 RESPIRATORY THERAPY	0.132828		65.00
66.00	06600 PHYSICAL THERAPY	0.731554		66.00
69.00	06900 ELECTROCARDIOLOGY	0.151285		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.251794		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715509		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.697753		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.328134		73.00
74.00	07400 RENAL DIALYSIS	1.047961		74.00
76.00	03950 ANCILLARY - OTHER	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.556765		76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.196469		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.616801		92.00
93.00	04040 FAMILY PRACTICE	0.591190		93.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	2.656318		96.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
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: 15-0048

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

Worksheet C
Part I
Date/Time Prepared:
5/22/2019 7:59 am

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	43,114,115		43,114,115	0	43,114,115	30.00
31.00	03100	INTENSIVE CARE UNIT	10,266,931		10,266,931	0	10,266,931	31.00
40.00	04000	SUBPROVIDER - IPF	7,504,854		7,504,854	0	7,504,854	40.00
41.00	04100	SUBPROVIDER - IRF	3,513,816		3,513,816	0	3,513,816	41.00
43.00	04300	NURSERY	926,124		926,124	0	926,124	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,664,004		33,664,004	0	33,664,004	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,604,557		2,604,557	0	2,604,557	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,608,733		23,608,733	0	23,608,733	54.00
59.00	05900	CARDIAC CATHETERIZATION	11,973,816		11,973,816	0	11,973,816	59.00
60.00	06000	LABORATORY	15,647,913		15,647,913	0	15,647,913	60.00
65.00	06500	RESPIRATORY THERAPY	3,513,936	0	3,513,936	0	3,513,936	65.00
66.00	06600	PHYSICAL THERAPY	12,129,051	0	12,129,051	0	12,129,051	66.00
69.00	06900	ELECTROCARDIOLOGY	3,776,710		3,776,710	0	3,776,710	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	932,791		932,791	0	932,791	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,481		26,481	0	26,481	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,068,477		19,068,477	0	19,068,477	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,779,640		33,779,640	0	33,779,640	73.00
74.00	07400	RENAL DIALYSIS	994,581		994,581	0	994,581	74.00
76.00	03950	ANCILLARY - OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	492,632		492,632	0	492,632	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	13,330,573		13,330,573	0	13,330,573	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,448,444		4,448,444	0	4,448,444	92.00
93.00	04040	FAMILY PRACTICE	3,699,979		3,699,979	0	3,699,979	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	678,065		678,065	0	678,065	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,873,360		3,873,360		3,873,360	116.00
200.00		Subtotal (see instructions)	253,569,583	0	253,569,583	0	253,569,583	200.00
201.00		Less Observation Beds	4,448,444		4,448,444		4,448,444	201.00
202.00		Total (see instructions)	249,121,139	0	249,121,139	0	249,121,139	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description		Title XIX			Hospital	Cost	TEFRA Inpatient Ratio	
		Charges			Cost or Other Ratio			
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	45,151,769		45,151,769			30.00
31.00	03100	INTENSIVE CARE UNIT	9,350,237		9,350,237			31.00
40.00	04000	SUBPROVIDER - IPF	10,470,112		10,470,112			40.00
41.00	04100	SUBPROVIDER - IRF	4,080,441		4,080,441			41.00
43.00	04300	NURSERY	2,087,423		2,087,423			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	54,670,875	96,998,131	151,669,006	0.221957	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,705,907	928,468	8,634,375	0.301650	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,002,655	96,175,022	125,177,677	0.188602	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	36,838,482	57,397,981	94,236,463	0.127061	0.000000	59.00
60.00	06000	LABORATORY	32,839,660	49,185,217	82,024,877	0.190770	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	23,610,522	2,844,338	26,454,860	0.132828	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,820,693	9,759,140	16,579,833	0.731554	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	5,357,055	19,607,224	24,964,279	0.151285	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38,955	3,665,631	3,704,586	0.251794	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,875	135	37,010	0.715509	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,163,965	10,164,457	27,328,422	0.697753	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,999,139	57,945,412	102,944,551	0.328134	0.000000	73.00
74.00	07400	RENAL DIALYSIS	890,101	58,962	949,063	1.047961	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	6,362	878,450	884,812	0.556765	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	15,467,468	52,383,166	67,850,634	0.196469	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,924,453	5,287,665	7,212,118	0.616801	0.000000	92.00
93.00	04040	FAMILY PRACTICE	12,868	6,245,661	6,258,529	0.591190	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	255,265	255,265	2.656318	0.000000	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,265,305	4,098,637	5,363,942			116.00
200.00		Subtotal (see instructions)	349,791,322	473,878,962	823,670,284			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	349,791,322	473,878,962	823,670,284			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/22/2019 7:59 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
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
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	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 - OTHER	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040 FAMILY PRACTICE	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
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: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part I Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,122,158	0	4,122,158	35,996	114.52	30.00
31.00	INTENSIVE CARE UNIT	1,197,654		1,197,654	5,246	228.30	31.00
40.00	SUBPROVIDER - IPF	720,106	0	720,106	9,557	75.35	40.00
41.00	SUBPROVIDER - IRF	549,147	0	549,147	3,725	147.42	41.00
43.00	NURSERY	76,309		76,309	2,015	37.87	43.00
200.00	Total (lines 30 through 199)	6,665,374		6,665,374	56,539		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	18,584	2,128,240				
31.00	INTENSIVE CARE UNIT	2,657	606,593				
40.00	SUBPROVIDER - IPF	5,396	406,589				
41.00	SUBPROVIDER - IRF	2,289	337,444				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	28,926	3,478,866				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description		Capital Related Cost (from Wkst. C, 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	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,811,552	151,669,006	0.018537	31,584,295	585,478	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	332,771	8,634,375	0.038540	25,856	996	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,004,201	125,177,677	0.023999	18,162,532	435,883	54.00
59.00	05900 CARDIAC CATHETERIZATION	870,264	94,236,463	0.009235	21,187,036	195,662	59.00
60.00	06000 LABORATORY	1,014,096	82,024,877	0.012363	18,176,123	224,711	60.00
65.00	06500 RESPIRATORY THERAPY	177,763	26,454,860	0.006719	13,909,553	93,458	65.00
66.00	06600 PHYSICAL THERAPY	1,763,717	16,579,833	0.106377	2,179,098	231,806	66.00
69.00	06900 ELECTROCARDIOLOGY	370,603	24,964,279	0.014845	3,244,263	48,161	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	150,589	3,704,586	0.040649	31,150	1,266	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,648	37,010	0.044529	16,086	716	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	482,542	27,328,422	0.017657	10,690,092	188,755	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	692,572	102,944,551	0.006728	23,459,925	157,838	73.00
74.00	07400 RENAL DIALYSIS	48,927	949,063	0.051553	574,330	29,608	74.00
76.00	03950 ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	91,989	884,812	0.103964	6,362	661	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	1,072,553	67,850,634	0.015808	11,583,677	183,115	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	425,316	7,212,118	0.058972	1,247,212	73,551	92.00
93.00	04040 FAMILY PRACTICE	306,517	6,258,529	0.048976	12,175	596	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	158,444	255,265	0.620704	0	0	96.00
200.00	Total (lines 50 through 199)	13,776,064	747,166,360		156,089,765	2,452,261	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	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	35,996	0.00	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,246	0.00	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	9,557	0.00	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	3,725	0.00	41.00
43.00	04300	NURSERY	0	0	2,015	0.00	43.00
200.00		Total (lines 30 through 199)	0	0	56,539		200.00
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
		9.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0				31.00
40.00	04000	SUBPROVIDER - IPF	0				40.00
41.00	04100	SUBPROVIDER - IRF	0				41.00
43.00	04300	NURSERY	0				43.00
200.00		Total (lines 30 through 199)	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description	Title XVIII						Total
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	PPS	
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	571,542	54.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
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	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	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 - OTHER	0	0	0	0	0	76.00	
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS							
91.00 09100 EMERGENCY	0	0	0	0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS							
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00	
200.00 Total (lines 50 through 199)	0	0	0	0	571,542	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description		Title XVIII				Hospital	PPS	
		All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	151,669,006	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	8,634,375	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	571,542	571,542	125,177,677	0.004566	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	94,236,463	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	82,024,877	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	26,454,860	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,579,833	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	24,964,279	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,704,586	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	37,010	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	27,328,422	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	102,944,551	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	949,063	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	884,812	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	67,850,634	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	7,212,118	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	6,258,529	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	255,265	0.000000	96.00
200.00		Total (lines 50 through 199)	0	571,542	571,542	747,166,360		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	31,584,295	0	34,918,836	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	25,856	0	15,900	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.004566	18,162,532	82,930	44,908,880	205,054	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	21,187,036	0	33,522,175	0	59.00
60.00	06000 LABORATORY	0.000000	18,176,123	0	8,869,791	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	13,909,553	0	1,313,471	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	2,179,098	0	58,900	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	3,244,263	0	6,275,552	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	31,150	0	1,834,188	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	16,086	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	10,690,092	0	5,216,566	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	23,459,925	0	26,973,571	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	574,330	0	50,439	0	74.00
76.00	03950 ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	6,362	0	527,491	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.000000	11,583,677	0	13,990,751	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,247,212	0	1,492,599	0	92.00
93.00	04040 FAMILY PRACTICE	0.000000	12,175	0	3,042,372	0	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00	Total (lines 50 through 199)		156,089,765	82,930	183,011,482	205,054	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/22/2019 7:59 am
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.221957	34,918,836	0	0	7,750,480	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.301650	15,900	0	0	4,796	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.188602	44,908,880	0	0	8,469,905	54.00
59.00 05900 CARDIAC CATHETERIZATION	0.127061	33,522,175	0	0	4,259,361	59.00
60.00 06000 LABORATORY	0.190770	8,869,791	0	0	1,692,090	60.00
65.00 06500 RESPIRATORY THERAPY	0.132828	1,313,471	0	0	174,466	65.00
66.00 06600 PHYSICAL THERAPY	0.731554	58,900	0	0	43,089	66.00
69.00 06900 ELECTROCARDIOLOGY	0.151285	6,275,552	0	0	949,397	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.251794	1,834,188	0	0	461,838	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715509	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.697753	5,216,566	0	0	3,639,875	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.328134	26,973,571	118	42,229	8,850,946	73.00
74.00 07400 RENAL DIALYSIS	1.047961	50,439	0	0	52,858	74.00
76.00 03950 ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0.556765	527,491	0	0	293,689	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0.196469	13,990,751	0	0	2,748,749	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.616801	1,492,599	0	0	920,637	92.00
93.00 04040 FAMILY PRACTICE	0.591190	3,042,372	0	0	1,798,620	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	2.656318	0	0	0	0	96.00
200.00 Subtotal (see instructions)		183,011,482	118	42,229	42,110,796	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 - line 201)		183,011,482	118	42,229	42,110,796	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/22/2019 7:59 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
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
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	39	13,857		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03950 ANCILLARY - OTHER	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00 04040 FAMILY PRACTICE	0	0		93.00
OTHER REIMBURSABLE COST CENTERS				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	39	13,857		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	39	13,857		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0048 Component CCN: 15-S048		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part II Date/Time Prepared: 5/22/2019 7:59 am		
				Title XVIII		Subprovider - IPF	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,811,552	151,669,006	0.018537	104,316	1,934	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	332,771	8,634,375	0.038540	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,004,201	125,177,677	0.023999	411,160	9,867	54.00
59.00	05900	CARDIAC CATHETERIZATION	870,264	94,236,463	0.009235	23,713	219	59.00
60.00	06000	LABORATORY	1,014,096	82,024,877	0.012363	713,207	8,817	60.00
65.00	06500	RESPIRATORY THERAPY	177,763	26,454,860	0.006719	425,481	2,859	65.00
66.00	06600	PHYSICAL THERAPY	1,763,717	16,579,833	0.106377	236,989	25,210	66.00
69.00	06900	ELECTROCARDIOLOGY	370,603	24,964,279	0.014845	16,404	244	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	150,589	3,704,586	0.040649	2,586	105	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,648	37,010	0.044529	63	3	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	482,542	27,328,422	0.017657	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	692,572	102,944,551	0.006728	1,143,079	7,691	73.00
74.00	07400	RENAL DIALYSIS	48,927	949,063	0.051553	4,244	219	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	91,989	884,812	0.103964	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,072,553	67,850,634	0.015808	558,105	8,823	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	7,212,118	0.000000	0	0	92.00
93.00	04040	FAMILY PRACTICE	306,517	6,258,529	0.048976	125	6	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	158,444	255,265	0.620704	0	0	96.00
200.00		Total (lines 50 through 199)	13,350,748	747,166,360		3,639,472	65,997	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	571,542	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	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 - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	571,542	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	151,669,006	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	8,634,375	0.000000	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	571,542	571,542	125,177,677	0.004566	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	94,236,463	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	82,024,877	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	26,454,860	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	16,579,833	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	24,964,279	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	3,704,586	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	37,010	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	27,328,422	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	102,944,551	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	949,063	0.000000	74.00
76.00	03950 ANCILLARY - OTHER	0	0	0	0	0.000000	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	884,812	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	0	0	67,850,634	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	7,212,118	0.000000	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	6,258,529	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	255,265	0.000000	96.00
200.00	Total (lines 50 through 199)	0	571,542	571,542	747,166,360		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/22/2019 7:59 am		
Title XVIII			Subprovider - IPF	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	104,316	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.004566	411,160	1,877	275	1	54.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	23,713	0	0	0	59.00
60.00 06000 LABORATORY	0.000000	713,207	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.000000	425,481	0	44	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	236,989	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	16,404	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	2,586	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	63	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	1,143,079	0	49	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	4,244	0	0	0	74.00
76.00 03950 ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0.000000	558,105	0	3,158	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0.000000	125	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00	Total (lines 50 through 199)	3,639,472	1,877	3,526	1	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/22/2019 7:59 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00		5.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.221957	0	0	0	0	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.301650	0	0	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.188602	275	0	0	52	54.00	
59.00 05900 CARDIAC CATHETERIZATION	0.127061	0	0	0	0	59.00	
60.00 06000 LABORATORY	0.190770	0	0	0	0	60.00	
65.00 06500 RESPIRATORY THERAPY	0.132828	44	0	0	6	65.00	
66.00 06600 PHYSICAL THERAPY	0.731554	0	0	0	0	66.00	
69.00 06900 ELECTROCARDIOLOGY	0.151285	0	0	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.251794	0	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715509	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.697753	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.328134	49	0	1,712	16	73.00	
74.00 07400 RENAL DIALYSIS	1.047961	0	0	0	0	74.00	
76.00 03950 ANCILLARY - OTHER	0.000000	0	0	0	0	76.00	
76.97 07697 CARDIAC REHABILITATION	0.556765	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS							
91.00 09100 EMERGENCY	0.196469	3,158	0	0	620	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.616801	0	0	0	0	92.00	
93.00 04040 FAMILY PRACTICE	0.591190	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS							
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	2.656318	0	0	0	0	96.00	
200.00	Subtotal (see instructions)		3,526	0	1,712	694	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		3,526	0	1,712	694	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/22/2019 7:59 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
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
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	562	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 ANCILLARY - OTHER	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS			
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS			
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00 Subtotal (see instructions)	0	562	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	562	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0048 Component CCN: 15-T048		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part II Date/Time Prepared: 5/22/2019 7:59 am		
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,811,552	151,669,006	0.018537	88,398	1,639	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	332,771	8,634,375	0.038540	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,004,201	125,177,677	0.023999	105,813	2,539	54.00
59.00	05900	CARDIAC CATHETERIZATION	870,264	94,236,463	0.009235	17,762	164	59.00
60.00	06000	LABORATORY	1,014,096	82,024,877	0.012363	274,761	3,397	60.00
65.00	06500	RESPIRATORY THERAPY	177,763	26,454,860	0.006719	507,849	3,412	65.00
66.00	06600	PHYSICAL THERAPY	1,763,717	16,579,833	0.106377	1,847,217	196,501	66.00
69.00	06900	ELECTROCARDIOLOGY	370,603	24,964,279	0.014845	585	9	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	150,589	3,704,586	0.040649	671	27	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,648	37,010	0.044529	135	6	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	482,542	27,328,422	0.017657	15	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	692,572	102,944,551	0.006728	552,558	3,718	73.00
74.00	07400	RENAL DIALYSIS	48,927	949,063	0.051553	16,718	862	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	91,989	884,812	0.103964	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,072,553	67,850,634	0.015808	2,152	34	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	7,212,118	0.000000	0	0	92.00
93.00	04040	FAMILY PRACTICE	306,517	6,258,529	0.048976	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	158,444	255,265	0.620704	0	0	96.00
200.00		Total (lines 50 through 199)	13,350,748	747,166,360		3,414,634	212,308	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	571,542	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	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 - OTHER	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50 through 199)	0	0	0	0	571,542	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/22/2019 7:59 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	151,669,006	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	8,634,375	0.000000	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	571,542	571,542	125,177,677	0.004566	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	94,236,463	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	82,024,877	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	26,454,860	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	16,579,833	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	24,964,279	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	3,704,586	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	37,010	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	27,328,422	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	102,944,551	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	949,063	0.000000	74.00
76.00	03950 ANCILLARY - OTHER	0	0	0	0	0.000000	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	884,812	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	0	0	67,850,634	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	7,212,118	0.000000	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	6,258,529	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	255,265	0.000000	96.00
200.00	Total (lines 50 through 199)	0	571,542	571,542	747,166,360		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0048 Component CCN: 15-T048		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/22/2019 7:59 am	
				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	88,398	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.004566	105,813	483	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	17,762	0	0	59.00
60.00	06000	LABORATORY	0.000000	274,761	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	507,849	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,847,217	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	585	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	671	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	135	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	15	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	552,558	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	16,718	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	2,152	0	880	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	96.00
200.00		Total (lines 50 through 199)		3,414,634	483	880	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/22/2019 7:59 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.221957	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.301650	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.188602	0	0	0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0.127061	0	0	0	0	59.00
60.00 06000 LABORATORY	0.190770	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.132828	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.731554	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.151285	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.251794	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715509	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.697753	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.328134	0	0	1,364	0	73.00
74.00 07400 RENAL DIALYSIS	1.047961	0	0	0	0	74.00
76.00 03950 ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0.556765	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0.196469	880	0	0	173	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.616801	0	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0.591190	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	2.656318	0	0	0	0	96.00
200.00	Subtotal (see instructions)	880	0	1,364	173	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00	Net Charges (line 200 - line 201)	880	0	1,364	173	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/22/2019 7:59 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
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
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	448	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 ANCILLARY - OTHER	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS			
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS			
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00 Subtotal (see instructions)	0	448	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	448	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/22/2019 7:59 am
	Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.221957	0	1,191,217	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.301650	0	46,503	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.188602	0	1,376,230	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.127061	0	185,136	0	0
60.00 06000 LABORATORY	0.190770	0	967,471	0	0
65.00 06500 RESPIRATORY THERAPY	0.132828	0	44,414	0	0
66.00 06600 PHYSICAL THERAPY	0.731554	0	647,910	0	0
69.00 06900 ELECTROCARDIOLOGY	0.151285	0	163,931	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.251794	0	44,349	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715509	0	0	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.697753	0	85,347	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.328134	0	659,684	0	0
74.00 07400 RENAL DIALYSIS	1.047961	0	3,588	0	0
76.00 03950 ANCILLARY - OTHER	0.000000	0	0	0	0
76.97 07697 CARDIAC REHABILITATION	0.556765	0	10,248	0	0
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY	0.196469	0	1,266,664	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.616801	0	192,060	0	0
93.00 04040 FAMILY PRACTICE	0.591190	0	72,144	0	0
OTHER REIMBURSABLE COST CENTERS					
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	2.656318	0	0	0	0
200.00 Subtotal (see instructions)		0	6,956,896	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 - line 201)		0	6,956,896	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/22/2019 7:59 am
		Title XIX	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	264,399	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	14,028	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	259,560	0		54.00
59.00 05900 CARDIAC CATHETERIZATION	23,524	0		59.00
60.00 06000 LABORATORY	184,564	0		60.00
65.00 06500 RESPIRATORY THERAPY	5,899	0		65.00
66.00 06600 PHYSICAL THERAPY	473,981	0		66.00
69.00 06900 ELECTROCARDIOLOGY	24,800	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	11,167	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	59,551	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	216,465	0		73.00
74.00 07400 RENAL DIALYSIS	3,760	0		74.00
76.00 03950 ANCILLARY - OTHER	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	5,706	0		76.97
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	248,860	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	118,463	0		92.00
93.00 04040 FAMILY PRACTICE	42,651	0		93.00
OTHER REIMBURSABLE COST CENTERS				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	1,957,378	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	1,957,378	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/22/2019 7:59 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		35,996	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		35,996	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)		32,282	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)		18,584	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)		43,114,115	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)		43,114,115	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)		43,114,115	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)		1,197.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		22,258,986	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)		22,258,986	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/22/2019 7:59 am	
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	10,266,931	5,246	1,957.10	2,657	5,200,015	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					39,369,789	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					66,828,790	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)					2,734,833	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,535,191	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					5,270,024	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					61,558,766	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)					3,714	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,197.75	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					4,448,444	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/22/2019 7:59 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	4,122,158	43,114,115	0.095610	4,448,444	425,316	90.00
91.00	Nursing School cost	0	43,114,115	0.000000	4,448,444	0	91.00
92.00	Allied health cost	0	43,114,115	0.000000	4,448,444	0	92.00
93.00	All other Medical Education	0	43,114,115	0.000000	4,448,444	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/22/2019 7:59 am
		Title XVIII	Subprovider - IPF	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)		9,557	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,557	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)		9,557	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)		5,396	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)		7,504,854	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)		7,504,854	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)		7,504,854	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)		785.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,237,317	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)		4,237,317	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/22/2019 7:59 am
				Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					962,090	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,199,407	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)					406,589	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					67,874	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					474,463	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					4,724,944	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: 15-0048 Component CCN: 15-S048		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/22/2019 7:59 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	720,106	7,504,854	0.095952	0	0	90.00
91.00	Nursing School cost	0	7,504,854	0.000000	0	0	91.00
92.00	Allied health cost	0	7,504,854	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,504,854	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/22/2019 7:59 am
		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)		3,725	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,725	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)		3,725	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)		2,289	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)		3,513,816	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)		3,513,816	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)		3,513,816	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)		943.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,159,237	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)		2,159,237	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/22/2019 7:59 am
				Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,712,668	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,871,905	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)					337,444	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					212,791	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					550,235	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					3,321,670	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: 15-0048 Component CCN: 15-T048		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/22/2019 7:59 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	549,147	3,513,816	0.156282	0	0	90.00
91.00	Nursing School cost	0	3,513,816	0.000000	0	0	91.00
92.00	Allied health cost	0	3,513,816	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,513,816	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/22/2019 7:59 am
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		35,996	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		35,996	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)		32,282	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)		716	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		2,015	15.00
16.00	Nursery days (title V or XIX only)		45	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)		43,114,115	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)		43,114,115	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)		43,114,115	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)		1,197.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		857,589	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)		857,589	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/22/2019 7:59 am		
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)	
Title XIX			Hospital Cost					
Cost Center Description			1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)		926,124	2,015	459.61	45	20,682	42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT		10,266,931	5,246	1,957.10	117	228,981	43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description								
							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						1,181,940	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						2,289,192	49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						3,714	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,197.75	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						4,448,444	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/22/2019 7:59 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	4,122,158	43,114,115	0.095610	4,448,444	425,316	90.00
91.00	Nursing School cost	0	43,114,115	0.000000	4,448,444	0	91.00
92.00	Allied health cost	0	43,114,115	0.000000	4,448,444	0	92.00
93.00	All other Medical Education	0	43,114,115	0.000000	4,448,444	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/22/2019 7:59 am
		Title XIX	Subprovider - IPF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			9,557 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			9,557 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)			9,557 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)			254 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			2,015 15.00
16.00	Nursery days (title V or XIX only)			45 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)			7,504,854 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)			7,504,854 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)			7,504,854 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)			785.27 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			199,459 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)			199,459 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1	
				Component CCN: 15-S048		Date/Time Prepared: 5/22/2019 7:59 am	
				Title XIX	Subprovider - IPF	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					199,459	0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048 Component CCN: 15-S048		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/22/2019 7:59 am	
		Title XIX		Subprovider - IPF		Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	720,106	7,504,854	0.095952	0	0	90.00
91.00	Nursing School cost	0	7,504,854	0.000000	0	0	91.00
92.00	Allied health cost	0	7,504,854	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,504,854	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1
		Component CCN: 15-T048		Date/Time Prepared: 5/22/2019 7:59 am
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,725	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,725	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)		3,725	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)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		2,015	15.00
16.00	Nursery days (title V or XIX only)		45	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)		3,513,816	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)		3,513,816	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)		3,513,816	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)		943.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1	
				Component CCN: 15-T048	Date/Time Prepared: 5/22/2019 7:59 am		
				Title XIX	Subprovider - IRF	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048 Component CCN: 15-T048		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/22/2019 7:59 am	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	549,147	3,513,816	0.156282	0	0	90.00
91.00	Nursing School cost	0	3,513,816	0.000000	0	0	91.00
92.00	Allied health cost	0	3,513,816	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,513,816	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/22/2019 7:59 am	
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		25,757,305	30.00
31.00	03100	INTENSIVE CARE UNIT		4,866,641	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.221957	31,584,295	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.301650	25,856	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188602	18,162,532	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.127061	21,187,036	59.00
60.00	06000	LABORATORY	0.190770	18,176,123	60.00
65.00	06500	RESPIRATORY THERAPY	0.132828	13,909,553	65.00
66.00	06600	PHYSICAL THERAPY	0.731554	2,179,098	66.00
69.00	06900	ELECTROCARDIOLOGY	0.151285	3,244,263	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251794	31,150	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715509	16,086	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.697753	10,690,092	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328134	23,459,925	73.00
74.00	07400	RENAL DIALYSIS	1.047961	574,330	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.556765	6,362	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.196469	11,583,677	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.616801	1,247,212	92.00
93.00	04040	FAMILY PRACTICE	0.591190	12,175	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2.656318	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		156,089,765	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)		156,089,765	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/22/2019 7:59 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		5,900,590		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.221957	104,316	23,154	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.301650	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.188602	411,160	77,546	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.127061	23,713	3,013	59.00
60.00	06000 LABORATORY	0.190770	713,207	136,058	60.00
65.00	06500 RESPIRATORY THERAPY	0.132828	425,481	56,516	65.00
66.00	06600 PHYSICAL THERAPY	0.731554	236,989	173,370	66.00
69.00	06900 ELECTROCARDIOLOGY	0.151285	16,404	2,482	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.251794	2,586	651	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715509	63	45	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.697753	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.328134	1,143,079	375,083	73.00
74.00	07400 RENAL DIALYSIS	1.047961	4,244	4,448	74.00
76.00	03950 ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.556765	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.196469	558,105	109,650	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.616801	0	0	92.00
93.00	04040 FAMILY PRACTICE	0.591190	125	74	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	2.656318	0	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,639,472	962,090	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		3,639,472		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/22/2019 7:59 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		2,507,052	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.221957	88,398	19,621 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.301650	0	0 52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.188602	105,813	19,957 54.00
59.00	05900 CARDIAC CATHETERIZATION	0.127061	17,762	2,257 59.00
60.00	06000 LABORATORY	0.190770	274,761	52,416 60.00
65.00	06500 RESPIRATORY THERAPY	0.132828	507,849	67,457 65.00
66.00	06600 PHYSICAL THERAPY	0.731554	1,847,217	1,351,339 66.00
69.00	06900 ELECTROCARDIOLOGY	0.151285	585	89 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.251794	671	169 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715509	135	97 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.697753	15	10 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.328134	552,558	181,313 73.00
74.00	07400 RENAL DIALYSIS	1.047961	16,718	17,520 74.00
76.00	03950 ANCILLARY - OTHER	0.000000	0	0 76.00
76.97	07697 CARDIAC REHABILITATION	0.556765	0	0 76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.196469	2,152	423 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.616801	0	0 92.00
93.00	04040 FAMILY PRACTICE	0.591190	0	0 93.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	2.656318	0	0 96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,414,634	1,712,668 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net charges (line 200 minus line 201)		3,414,634	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/22/2019 7:59 am	
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		1,458,707		30.00
31.00	03100 INTENSIVE CARE UNIT		294,607		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		174,562		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.221957	430,720	95,601	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.301650	309,788	93,448	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.188602	599,395	113,047	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.127061	105,868	13,452	59.00
60.00	06000 LABORATORY	0.190770	747,439	142,589	60.00
65.00	06500 RESPIRATORY THERAPY	0.132828	455,066	60,446	65.00
66.00	06600 PHYSICAL THERAPY	0.731554	119,881	87,699	66.00
69.00	06900 ELECTROCARDIOLOGY	0.151285	76,300	11,543	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.251794	586	148	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715509	3,260	2,333	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.697753	116,704	81,431	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.328134	1,120,676	367,732	73.00
74.00	07400 RENAL DIALYSIS	1.047961	33,288	34,885	74.00
76.00	03950 ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.556765	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.196469	394,825	77,571	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.616801	25	15	92.00
93.00	04040 FAMILY PRACTICE	0.591190	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	2.656318	0	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		4,513,821	1,181,940	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		4,513,821		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/22/2019 7:59 am	
Cost Center Description		Title XIX	Subprovider - IPF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		462,797	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.221957	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.301650	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188602	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.127061	0	59.00
60.00	06000	LABORATORY	0.190770	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.132828	0	65.00
66.00	06600	PHYSICAL THERAPY	0.731554	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.151285	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251794	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715509	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.697753	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328134	0	73.00
74.00	07400	RENAL DIALYSIS	1.047961	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.556765	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.196469	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.616801	0	92.00
93.00	04040	FAMILY PRACTICE	0.591190	0	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2.656318	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	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)		0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/22/2019 7:59 am	
Cost Center Description		Title XIX	Subprovider - IRF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		81,325	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.221957	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.301650	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188602	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.127061	0	59.00
60.00	06000	LABORATORY	0.190770	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.132828	0	65.00
66.00	06600	PHYSICAL THERAPY	0.731554	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.151285	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251794	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715509	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.697753	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328134	0	73.00
74.00	07400	RENAL DIALYSIS	1.047961	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.556765	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.196469	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.616801	0	92.00
93.00	04040	FAMILY PRACTICE	0.591190	0	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2.656318	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	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)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/22/2019 7:59 am
		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)		39,532,747	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		11,545,677	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)		893,439	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		5,992,445	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		152.82	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		13.48	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		13.48	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.088208	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.088942	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.088208	21.00
22.00	IME payment adjustment (see instructions)		2,401,605	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		281,753	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)		2,401,605	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		281,753	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.78	30.00
31.00	Percentage of Medicaid patient days (see instructions)		21.31	31.00
32.00	Sum of lines 30 and 31		26.09	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.74	33.00
34.00	Disproportionate share adjustment (see instructions)		1,371,456	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/22/2019 7:59 am	
		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)		0.000381566	0.000381928	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		2,581,942	3,074,238	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,931,151	774,877	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,706,028		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 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		58,450,952		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		67,032,792		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			67,314,545	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			4,380,771	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).			464,600	52.00
53.00	Nursing and Allied Health Managed Care payment			57,592	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			82,930	58.00
59.00	Total (sum of amounts on lines 49 through 58)			72,300,438	59.00
60.00	Primary payer payments			30,698	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			72,269,740	61.00
62.00	Deductibles billed to program beneficiaries			5,386,940	62.00
63.00	Coinurance billed to program beneficiaries			85,760	63.00
64.00	Allowable bad debts (see instructions)			547,405	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			355,813	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			269,786	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			67,152,853	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			277,007	70.93
70.94	HRR adjustment amount (see instructions)			-79,066	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/22/2019 7:59 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
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	1.00	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)			67,350,794	71.00
71.01	Sequestration adjustment (see instructions)			1,347,016	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			65,849,411	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)			154,367	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, 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	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	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	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
Comparison 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: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/22/2019 7:59 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		13,896	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		41,905,742	2.00
3.00	OPPTS payments		48,288,252	3.00
4.00	Outlier payment (see instructions)		18,342	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		205,054	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		13,896	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		42,347	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)		42,347	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		42,347	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		28,451	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		13,896	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)		48,511,648	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)		8,612,240	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)		39,913,304	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		257,924	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)		40,171,228	30.00
31.00	Primary payer payments		7,564	31.00
32.00	Subtotal (line 30 minus line 31)		40,163,664	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)		1,925,835	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		1,251,793	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,514,362	36.00
37.00	Subtotal (see instructions)		41,415,457	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-318	38.00
39.00	OTHER ADJUSTMENTS		-411	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)		41,415,364	40.00
40.01	Sequestration adjustment (see instructions)		828,307	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		39,823,175	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		763,882	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: 15-0048 Component CCN: 15-S048	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/22/2019 7:59 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		562	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		693	2.00
3.00	OPPS payments		1,035	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		1	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		562	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,712	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)		1,712	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,712	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,150	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)		562	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)		1,036	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)		103	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)		1,495	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)		1,495	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,495	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,495	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)		1,495	40.00
40.01	Sequestration adjustment (see instructions)		30	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		1,450	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		15	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: 15-0048 Component CCN: 15-T048	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/22/2019 7:59 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		448	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		173	2.00
3.00	OPPS payments		359	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)		448	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,364	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)		1,364	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,364	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		916	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)		448	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)		359	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)		807	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)		807	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		807	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		807	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)		807	40.00
40.01	Sequestration adjustment (see instructions)		16	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		779	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		12	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: 15-0048		Period: From 01/01/2018 To 12/31/2018		Worksheet E-1 Part I Date/Time Prepared: 5/22/2019 7:59 am	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		65,863,511		39,849,075	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	08/13/2018	40,400		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	09/17/2018	54,500	09/17/2018	25,900		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)		-14,100		-25,900		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)		65,849,411		39,823,175		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		154,367		763,882		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		66,003,778		40,587,057		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: 15-0048
Component CCN: 15-S048

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

Worksheet E-1
Part I
Date/Time Prepared:
5/22/2019 7:59 am

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		4,777,763		1,450	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)		4,777,763		1,450	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		43,421		15	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,821,184		1,465	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: 15-0048
Component CCN: 15-T048

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

Worksheet E-1
Part I
Date/Time Prepared:
5/22/2019 7:59 am

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider				779	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		3,706,351		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)		3,706,351		779	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		42,873		12	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,749,224		791	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: 15-0048

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

Worksheet E-1
Part II
Date/Time Prepared:
5/22/2019 7:59 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part II Date/Time Prepared: 5/22/2019 7:59 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			5,345,956 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			26,183,562 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			5,345,956 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			5,345,956 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			5,345,956 18.00
19.00	Deductibles			341,364 19.00
20.00	Subtotal (line 18 minus line 19)			5,004,592 20.00
21.00	Coinsurance			129,309 21.00
22.00	Subtotal (line 20 minus line 21)			4,875,283 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			65,255 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			42,416 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			50,907 25.00
26.00	Subtotal (sum of lines 22 and 24)			4,917,699 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			1,877 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			4,919,576 31.00
31.01	Sequestration adjustment (see instructions)			98,392 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			4,777,763 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			43,421 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part III Date/Time Prepared: 5/22/2019 7:59 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			3,631,687 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0137 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			156,889 3.00
4.00	Outlier Payments			60,833 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)			10.205479 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)			3,849,409 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			3,849,409 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			3,849,409 19.00
20.00	Deductibles			21,440 20.00
21.00	Subtotal (line 19 minus line 20)			3,827,969 21.00
22.00	Coinurance			4,020 22.00
23.00	Subtotal (line 21 minus line 22)			3,823,949 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			2,010 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			1,307 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			3,825,256 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)			483 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)			3,825,739 32.00
32.01	Sequestration adjustment (see instructions)			76,515 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			3,706,351 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)			42,873 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			60,833 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/22/2019 7:59 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		2,289,192		1.00
2.00	Medical and other services			1,957,378	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		2,289,192	1,957,378	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		2,289,192	1,957,378	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		4,513,821	6,956,896	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		4,513,821	6,956,896	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		4,513,821	6,956,896	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,224,629	4,999,518	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		2,289,192	1,957,378	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		2,289,192	1,957,378	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2,289,192	1,957,378	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		2,289,192	1,957,378	36.00
37.00	TO ZERO OUT MEDICAID		-2,289,192	-1,957,378	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/22/2019 7:59 am
		Title XIX	Subprovider - IPF	Cost
			Inpatient 1.00	Outpatient 2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital /SNF/NF services		199,459	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		199,459	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		199,459	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		0	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		199,459	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		199,459	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	31.00
32.00	Deductibles		0	32.00
33.00	Coinurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	40.00
41.00	Interim payments		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/22/2019 7:59 am	
		Title XIX	Subprovider - IRF	Cost	
			Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital /SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet E-4 Date/Time Prepared: 5/22/2019 7:59 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			13.48	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	13.48	0.00	13.48	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	13.48	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	13.48	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	13.48	0.00		17.00
18.00	Per resident amount	85,000.00	85,000.00		18.00
19.00	Approved amount for resident costs	1,145,800	0	1,145,800	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			13.48	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,145,800	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	28,926	3,766		26.00
27.00	Total Inpatient Days (see instructions)	51,000	51,000		27.00
28.00	Ratio of inpatient days to total inpatient days	0.567176	0.073843		28.00
29.00	Program direct GME amount	649,870	84,609		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		11,955		30.00
31.00	Net Program direct GME amount			722,524	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet E-4 Date/Time Prepared: 5/22/2019 7:59 am
		Title XVIII	Hospital	PPS
		1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		949,063	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		75,900,102	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		30,698	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		75,869,404	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		42,126,569	42.00
43.00	Primary payer payments (see instructions)		7,564	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		42,119,005	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		117,988,409	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.643024	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.356976	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		722,524	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		464,600	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		257,924	50.00

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

Provider CCN: 15-0048

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

Worksheet G

Date/Time Prepared:
5/22/2019 7:59 am

		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	22,742,836	0	0	0	1.00
2.00	Temporary investments	289,971,709	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	125,459,308	0	0	0	4.00
5.00	Other receivable	-923,225	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-68,924,747	0	0	0	6.00
7.00	Inventory	6,570,398	0	0	0	7.00
8.00	Prepaid expenses	5,033,520	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-1	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	379,929,798	0	0	0	11.00
FIXED ASSETS						
12.00	Land	14,477,094	0	0	0	12.00
13.00	Land improvements	14,989,210	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	297,210,638	0	0	0	15.00
16.00	Accumulated depreciation	-141,966,941	0	0	0	16.00
17.00	Leasehold improvements	12,458,447	0	0	0	17.00
18.00	Accumulated depreciation	-7,175,092	0	0	0	18.00
19.00	Fixed equipment	2,182,235	0	0	0	19.00
20.00	Accumulated depreciation	-1,505,214	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	182,552,200	0	0	0	23.00
24.00	Accumulated depreciation	-150,926,554	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	222,296,023	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	69,604,154	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	69,604,154	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	671,829,975	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	19,610,621	0	0	0	37.00
38.00	Salaries, wages, and fees payable	21,532,268	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,818,388	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	-36,621	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	48,924,656	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	215,389,425	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,279,640	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	217,669,065	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	266,593,721	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	405,236,254				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)	405,236,254	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	671,829,975	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0048

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

Worksheet G-1

Date/Time Prepared:
5/22/2019 7:59 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		432,860,072		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-27,623,862				2.00
3.00	Total (sum of line 1 and line 2)		405,236,210		0		3.00
4.00	ROUNDING	44		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)		44		0		10.00
11.00	Subtotal (line 3 plus line 10)		405,236,254		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)		405,236,254		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	ROUNDING		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0048

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	55,068,173		55,068,173	1.00
2.00	SUBPROVIDER - IPF	10,503,695		10,503,695	2.00
3.00	SUBPROVIDER - IRF	4,109,657		4,109,657	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)	69,681,525		69,681,525	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	11,327,309		11,327,309	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	11,327,309		11,327,309	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	81,008,834		81,008,834	17.00
18.00	Ancillary services	262,232,756	424,202,424	686,435,180	18.00
19.00	Outpatient services	14,936,003	59,521,697	74,457,700	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	97,189	5,024,728	5,121,917	26.00
27.00	OTHER	78,369,187	100,822,460	179,191,647	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	436,643,969	589,571,309	1,026,215,278	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		475,249,474		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)		475,249,474		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 5/22/2019 7:59 am
				1.00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			1,026,215,278 1.00
2.00	Less contractual allowances and discounts on patients' accounts			594,059,301 2.00
3.00	Net patient revenues (line 1 minus line 2)			432,155,977 3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			475,249,474 4.00
5.00	Net income from service to patients (line 3 minus line 4)			-43,093,497 5.00
OTHER INCOME				
6.00	Contributions, donations, bequests, etc			2,760,000 6.00
7.00	Income from investments			-5,972,027 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			9,364 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			357,518 13.00
14.00	Revenue from meals sold to employees and guests			3,712,515 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			18,000 17.00
18.00	Revenue from sale of medical records and abstracts			52,949 18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			44,230 19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0 20.00
21.00	Rental of vending machines			15,339 21.00
22.00	Rental of hospital space			6,392,370 22.00
23.00	Governmental appropriations			0 23.00
24.00	OTHER INCOME			8,079,377 24.00
25.00	Total other income (sum of lines 6-24)			15,469,635 25.00
26.00	Total (line 5 plus line 25)			-27,623,862 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)			-27,623,862 29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0048

Period: From 01/01/2018

Worksheet 0

Hospice CCN: 15-1524

To 12/31/2018

Date/Time Prepared: 5/22/2019 7:59 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		1,650	1,650	-1,650	0
2.00	CAP REL COSTS-MVBLE EQUIP*		5,127	5,127	0	5,127
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	69,231	69,231	26,058	95,289
4.00	ADMINISTRATIVE & GENERAL*	585,611	33,664	619,275	18,452	637,727
5.00	PLANT OPERATION & MAINTENANCE*	0	-29	-29	0	-29
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0
7.00	HOUSEKEEPING*	0	0	0	0	0
8.00	DIETARY*	0	4,418	4,418	0	4,418
9.00	NURSING ADMINISTRATION*	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0
11.00	MEDICAL RECORDS*	0	0	0	0	0
12.00	STAFF TRANSPORTATION*	0	104,826	104,826	0	104,826
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0
14.00	PHARMACY*	0	143,578	143,578	0	143,578
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES					
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0
26.00	PHYSICIAN SERVICES**	0	187,321	187,321	0	187,321
27.00	NURSE PRACTITIONER**	0	0	0	0	0
28.00	REGISTERED NURSE**	211,977	0	211,977	202,394	414,371
29.00	LPN/LVN**	33,010	0	33,010	80,315	113,325
30.00	PHYSICAL THERAPY**	0	0	0	0	0
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0
35.00	DIETARY COUNSELING**	0	0	0	0	0
36.00	COUNSELING - OTHER**	0	0	0	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	99,585	0	99,585	58,898	158,483
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0
40.00	IMAGING SERVICES**	0	0	0	0	0
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	137,881	137,881	23,751	161,632
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0
43.00	OUTPATIENT SERVICES**	0	0	0	0	0
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	800,507	800,507	0	800,507
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0
62.00	FUNDRAISING*	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0
66.00	RESIDENTIAL CARE*	0	0	0	0	0
67.00	ADVERTISING*	0	982	982	0	982
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0
69.00	THRIFT STORE*	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0
100.00	TOTAL	930,183	1,489,156	2,419,339	408,218	2,827,557

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0048

Period: From 01/01/2018

Worksheet 0

Hospice CCN: 15-1524

To 12/31/2018

Date/Time Prepared: 5/22/2019 7:59 am

		ADJUSTMENTS	TOTAL (col . 5 ± col . 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	5,127	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	-316	94,973	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	637,727	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	-29	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	4,418	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	104,826	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	143,578	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	187,321	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	414,371	28.00
29.00	LPN/LVN**	0	113,325	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	158,483	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	161,632	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	800,507	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	-982	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	-1,298	2,826,259	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE	Provider CCN: 15-0048 Hospice CCN: 15-1524	Period: From 01/01/2018 To 12/31/2018	Worksheet 0-2 Date/Time Prepared: 5/22/2019 7:59 am
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	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00						25.00
26.00		187,321	187,321	0	187,321	26.00
27.00	0	0	0	0	0	27.00
28.00	211,977	0	211,977	0	211,977	28.00
29.00	33,010	0	33,010	0	33,010	29.00
30.00	0	0	0	0	0	30.00
31.00	0	0	0	0	0	31.00
32.00	0	0	0	0	0	32.00
33.00	0	0	0	0	0	33.00
34.00	0	0	0	0	0	34.00
35.00	0	0	0	0	0	35.00
36.00	0	0	0	0	0	36.00
37.00	99,585	0	99,585	0	99,585	37.00
38.00	0	0	0	0	0	38.00
39.00	0	0	0	0	0	39.00
40.00	0	0	0	0	0	40.00
41.00	0	0	0	0	0	41.00
42.00	0	137,881	137,881	0	137,881	42.00
42.50	0	0	0	0	0	42.50
43.00	0	0	0	0	0	43.00
44.00	0	0	0	0	0	44.00
45.00	0	0	0	0	0	45.00
46.00	0	800,507	800,507	0	800,507	46.00
100.00	344,572	1,125,709	1,470,281	0	1,470,281	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

	ADJUSTMENTS	TOTAL (col. 5	
	6.00	± col. 6)	
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00			25.00
26.00	0	187,321	26.00
27.00	0	0	27.00
28.00	0	211,977	28.00
29.00	0	33,010	29.00
30.00	0	0	30.00
31.00	0	0	31.00
32.00	0	0	32.00
33.00	0	0	33.00
34.00	0	0	34.00
35.00	0	0	35.00
36.00	0	0	36.00
37.00	0	99,585	37.00
38.00	0	0	38.00
39.00	0	0	39.00
40.00	0	0	40.00
41.00	0	0	41.00
42.00	0	137,881	42.00
42.50	0	0	42.50
43.00	0	0	43.00
44.00	0	0	44.00
45.00	0	0	45.00
46.00	0	800,507	46.00
100.00	0	1,470,281	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPIRE CARE

Provider CCN: 15-0048

Period: From 01/01/2018

Worksheet 0-3

Hospice CCN: 15-1524

To 12/31/2018

Date/Time Prepared: 5/22/2019 7:59 am

	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	22,506	28.00
29.00	LPN/LVN	0	0	0	8,931	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	6,549	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	2,641	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	40,627	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	25.00
26.00	PHYSICIAN SERVICES	0	26.00
27.00	NURSE PRACTITIONER	0	27.00
28.00	REGISTERED NURSE	22,506	28.00
29.00	LPN/LVN	8,931	29.00
30.00	PHYSICAL THERAPY	0	30.00
31.00	OCCUPATIONAL THERAPY	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	33.00
34.00	SPIRITUAL COUNSELING	0	34.00
35.00	DIETARY COUNSELING	0	35.00
36.00	COUNSELING - OTHER	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	6,549	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	38.00
39.00	PATIENT TRANSPORTATION	0	39.00
40.00	IMAGING SERVICES	0	40.00
41.00	LABS & DIAGNOSTICS	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	2,641	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	42.50
43.00	OUTPATIENT SERVICES	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	46.00
100.00	TOTAL *	40,627	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL
INPATIENT CARE

Provider CCN: 15-0048

Period: From 01/01/2018

Worksheet 0-4

Hospice CCN: 15-1524

To 12/31/2018

Date/Time Prepared: 5/22/2019 7:59 am

	Hospice I					SUBTOTAL
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS		
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	179,888	28.00
29.00	LPN/LVN	0	0	0	71,384	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	52,349	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	21,110	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	324,731	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	25.00
26.00	PHYSICIAN SERVICES	0	26.00
27.00	NURSE PRACTITIONER	0	27.00
28.00	REGISTERED NURSE	179,888	28.00
29.00	LPN/LVN	71,384	29.00
30.00	PHYSICAL THERAPY	0	30.00
31.00	OCCUPATIONAL THERAPY	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	33.00
34.00	SPIRITUAL COUNSELING	0	34.00
35.00	DIETARY COUNSELING	0	35.00
36.00	COUNSELING - OTHER	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	52,349	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	38.00
39.00	PATIENT TRANSPORTATION	0	39.00
40.00	IMAGING SERVICES	0	40.00
41.00	LABS & DIAGNOSTICS	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	21,110	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	42.50
43.00	OUTPATIENT SERVICES	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	46.00
100.00	TOTAL *	324,731	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-0048
 Hospice CCN: 15-1524

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

Worksheet 0-5
 Date/Time Prepared:
 5/22/2019 7:59 am

Descriptions		Hospice I			
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of col s. 1 + 2)	
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	7,069	7,069	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,127	0	5,127	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	94,973	229,264	324,237	3.00
4.00	ADMINISTRATIVE & GENERAL	637,727	508,234	1,145,961	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	31,816	31,816	7.00
8.00	DIETARY	4,418	0	4,418	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	38	38	10.00
11.00	MEDICAL RECORDS	0	51,794	51,794	11.00
12.00	STAFF TRANSPORTATION	104,826	0	104,826	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	143,578	178,223	321,801	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	40,663	40,663	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,470,281	0	1,470,281	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	40,627	0	40,627	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	324,731	0	324,731	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	-29	0	-29	99.00
100.00	TOTAL	2,826,259	1,047,101	3,873,360	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0048

Period: From 01/01/2018

Worksheet 0-6

Hospice CCN: 15-1524

To 12/31/2018

Part I
Date/Time Prepared:
5/22/2019 7:59 am

Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
	0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIX	7,069	7,069			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,127		5,127		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	324,237	0	0	324,237	3.00
4.00	ADMINISTRATIVE & GENERAL	1,145,961	7,069	0	151,385	1,304,415
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0
7.00	HOUSEKEEPING	31,816	0	0	0	31,816
8.00	DIETARY	4,418	0	0	0	4,418
9.00	NURSING ADMINISTRATION	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES	38	0	0	0	38
11.00	MEDICAL RECORDS	51,794	0	0	0	51,794
12.00	STAFF TRANSPORTATION	104,826	0	0	0	104,826
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0
14.00	PHARMACY	321,801	0	0	0	321,801
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0
16.00	OTHER GENERAL SERVICE	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		40,663
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0
51.00	HOSPICE ROUTINE HOME CARE	1,470,281			86,799	1,557,080
52.00	HOSPICE INPATIENT RESPIRE CARE	40,627	0	565	9,569	50,761
53.00	HOSPICE GENERAL INPATIENT CARE	324,731	0	4,562	76,484	405,777
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0
61.00	VOLUNTEER PROGRAM	0	0	0	0	0
62.00	FUNDRAISING	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0
66.00	RESIDENTIAL CARE	0	0	0	0	0
67.00	ADVERTISING	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0
69.00	THRIFT STORE	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD	0				0
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0
99.00	NEGATIVE COST CENTER	-29	0	0	0	99.00
100.00	TOTAL	3,873,360	7,069	5,127	324,237	3,873,360

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0048

Period: From 01/01/2018

Worksheet 0-6

Hospice CCN: 15-1524

To 12/31/2018

Part I
Date/Time Prepared:
5/22/2019 7:59 am

Descriptions	Hospice I					
	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00 ADMINISTRATIVE & GENERAL	1,304,415					4.00
5.00 PLANT OPERATION & MAINTENANCE	0	0				5.00
6.00 LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00 HOUSEKEEPING	16,155	0		47,971		7.00
8.00 DIETARY	2,243	0		0	6,661	8.00
9.00 NURSING ADMINISTRATION	0	0		0		9.00
10.00 ROUTINE MEDICAL SUPPLIES	19	0		0		10.00
11.00 MEDICAL RECORDS	26,299	0		0		11.00
12.00 STAFF TRANSPORTATION	53,226	0		0		12.00
13.00 VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00 PHARMACY	163,397	0		0		14.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00 OTHER GENERAL SERVICE	0	0		0		16.00
17.00 PATIENT/RESIDENTIAL CARE SERVICES	20,647	0		0		17.00
LEVEL OF CARE						
50.00 HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00 HOSPICE ROUTINE HOME CARE	790,619					51.00
52.00 HOSPICE INPATIENT RESPIRE CARE	25,774	0	0	5,282	741	52.00
53.00 HOSPICE GENERAL INPATIENT CARE	206,036	0	0	42,689	5,920	53.00
NONREIMBURSABLE COST CENTERS						
60.00 BEREAVEMENT PROGRAM	0	0		0		60.00
61.00 VOLUNTEER PROGRAM	0	0		0		61.00
62.00 FUNDRAISING	0	0		0		62.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00 PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00 OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00 RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00 ADVERTISING	0	0		0		67.00
68.00 TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00 THIRFT STORE	0	0		0		69.00
70.00 NURSING FACILITY ROOM & BOARD						70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00 NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00 TOTAL	1,304,415	0	0	47,971	6,661	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0048

Period: From 01/01/2018

Worksheet 0-6

Hospice CCN: 15-1524

To 12/31/2018

Part I
Date/Time Prepared:
5/22/2019 7:59 am

Descriptions	Hospice I					
	NURSING ADMINISTRATIVE	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
	9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00	0					9.00
10.00	0	57				10.00
11.00	0		78,093			11.00
12.00	0			158,052		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
LEVEL OF CARE						
50.00	0	0	0	158,052	0	50.00
51.00	0	54	74,098	0	0	51.00
52.00	0	0	444	0	0	52.00
53.00	0	3	3,551	0	0	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0			0	0	60.00
61.00	0			0	0	61.00
62.00	0			0	0	62.00
63.00	0			0	0	63.00
64.00	0			0	0	64.00
65.00	0			0	0	65.00
66.00	0			0	0	66.00
67.00	0			0	0	67.00
68.00	0			0	0	68.00
69.00	0			0	0	69.00
70.00						70.00
71.00	0			0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	0	57	78,093	158,052	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 15-0048 Hospice CCN: 15-1524	Period: From 01/01/2018 To 12/31/2018	Worksheet 0-6 Part I Date/Time Prepared: 5/22/2019 7:59 am
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Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00	485,198					14.00
15.00	0	0				15.00
16.00	0		0			16.00
17.00				61,310		17.00
LEVEL OF CARE						
50.00	0	0	0		158,052	50.00
51.00	460,377	0	0		2,882,228	51.00
52.00	2,761	0	0	6,819	92,582	52.00
53.00	22,060	0	0	54,491	740,527	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0		0		0	60.00
61.00	0		0		0	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		0	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	0	66.00
67.00	0		0		0	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00	0		0		0	70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	-29	99.00
100.00	485,198	0	0	61,310	3,873,360	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPI CE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0048

Period: From 01/01/2018

Worksheet 0-6

Hospice CCN: 15-1524

To 12/31/2018

Part II
Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Descriptions		Hospice I					
		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	445					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		445				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,287,139			3.00
4.00	ADMINISTRATIVE & GENERAL	445	0	600,960	-1,304,415	2,568,974	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	31,816	7.00
8.00	DIETARY	0	0	0	0	4,418	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	38	10.00
11.00	MEDICAL RECORDS	0	0	0	0	51,794	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	104,826	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	321,801	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	40,663	17.00
LEVEL OF CARE							
50.00	HOSPI CE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPI CE ROUTINE HOME CARE			344,572	0	1,557,080	51.00
52.00	HOSPI CE INPATIENT RESPI TE CARE	0	49	37,986	0	50,761	52.00
53.00	HOSPI CE GENERAL INPATIENT CARE	0	396	303,621	0	405,777	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPI CE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	7,069	5,127	324,237		1,304,415	100.00
101.00	UNIT COST MULTIPLIER	15.885393	11.521348	0.251905		0.507757	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0048

Period: From 01/01/2018

Worksheet 0-6

Hospice CCN: 15-1524

To 12/31/2018

Part II
Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		445			7.00
8.00	DIETARY	0		0	953		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	49	106	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	396	847	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)			47,971	6,661	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	107.800000	6.989507	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0048

Period: From 01/01/2018

Worksheet 0-6

Hospice CCN: 15-1524

To 12/31/2018

Part II
Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	18,629					10.00
11.00	MEDICAL RECORDS		18,629				11.00
12.00	STAFF TRANSPORTATION			1,000			12.00
13.00	VOLUNTEER SERVICE COORDINATION				0		13.00
14.00	PHARMACY					18,629	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES				0	0	15.00
16.00	OTHER GENERAL SERVICE				0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	1,000	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	17,676	17,676	0	0	17,676	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	106	106	0	0	106	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	847	847	0	0	847	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	57	78,093	158,052	0	485,198	100.00
101.00	UNIT COST MULTIPLIER	0.003060	4.192012	158.052000	0.000000	26.045306	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0048

Period: From 01/01/2018

Worksheet 0-6

Hospice CCN: 15-1524

To 12/31/2018

Part II
Date/Time Prepared:
5/22/2019 7:59 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	18,629				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			953		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	17,676	0			51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	106	0	106		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	847	0	847		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	61,310		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	64.333683		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-0048

Period: From 01/01/2018

Worksheet 0-7

Hospice CCN: 15-1524

To 12/31/2018

Date/Time Prepared: 5/22/2019 7:59 am

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				0	1.00	2.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.731554	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.328134	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	2.656318	0	0	0	5.00
6.00	LABORATORY	60.00	0.190770	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.715509	0	0	0	7.00
8.00	FAMILY PRACTICE	93.00	0.591190	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	ANCILLARY - OTHER	76.00	0.000000	0	0	0	10.00
10.97	CARDIAC REHABILITATION	76.97	0.556765	0	0	0	10.97
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
			HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)
			5.00	6.00	7.00	8.00	9.00
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	FAMILY PRACTICE	0	0	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	ANCILLARY - OTHER	0	0	0	0	0	10.00
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97
11.00	Totals (sum of lines 1-11)						11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0048

Period: From 01/01/2018

Worksheet 0-8

Hospice CCN: 15-1524

To 12/31/2018

Date/Time Prepared: 5/22/2019 7:59 am

		Hospice I		TOTAL	
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID		
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			158,052	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)				4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			2,882,228	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			17,676	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			163.06	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	14,363	973		9.00
10.00	Program cost (line 8 times line 9)	2,342,031	158,657		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			92,582	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			106	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			873.42	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	97	9		14.00
15.00	Program cost (line 13 times line 14)	84,722	7,861		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			740,527	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			847	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			874.29	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	835	12		19.00
20.00	Program cost (line 18 times line 19)	730,032	10,491		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,873,389	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			18,629	22.00
23.00	Average cost per diem (line 21 divided by line 22)			207.92	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0048	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/22/2019 7:59 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		4,137,979	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		90,514	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)		105.29	3.00
4.00	Number of interns & residents (see instructions)		13.48	4.00
5.00	Indirect medical education percentage (see instructions)		3.68	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)		152,278	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		4,380,771	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