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: 15-0047	Period: From 06/01/2017 To 05/31/2018	Worksheet S Parts I-III Date/Time Prepared: 10/31/2018 1:14 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 10/31/2018 Time: 1:14 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST JOSEPH MEDICAL CENTER (15-0047) for the cost reporting period beginning 06/01/2017 and ending 05/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	483,970	3,838	0	0	1.00
2.00	Subprovider - IPF	0	9	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	101	0		0	7.00
200.00	Total	0	484,080	3,838	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: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 10/31/2018 1:09 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 700 BROADWAY STREET	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46802	County: ALLEN	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	ST JOSEPH MEDICAL CENTER	150047	23060	1	07/01/1996	N	P	P	3.00
4.00	Subprovider - IPF	ST JOSPEH GENERATIONS	15S047	23060	4	06/01/2003	N	P	P	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	SKILLED NURSING FACILITY ST JOSEPH	155356	23060		04/01/1990	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	06/01/2017	05/31/2018	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	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	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,712	446	29	69	6,586	100	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 10/31/2018 1:09 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	Y	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	Y	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	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)	N			60.00

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 10/31/2018 1:09 pm

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 10/31/2018 1:09 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	344,221	84,445	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	679005	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 10/31/2018 1:09 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS, INC.	Contractor's Number: 10301	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	06/01/2017	05/31/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 10/31/2018 1:09 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	08/30/2018	Y	08/30/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 10/31/2018 1:09 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	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?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2016	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 10/31/2018 1:09 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANGER, REVENUE MANAGEMENT		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: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 10/31/2018 1:09 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	70	27,930	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)		70	27,930	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
8.01	NEONATAL INTENSIVE CARE UNIT	31.01	0	4,760	0.00	0	8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	12	4,380	0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		82	37,070	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	19	6,935		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	20	7,300		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		121				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	2,720			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: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 10/31/2018 1:09 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,946	991	16,903			1.00
2.00	HMO and other (see instructions)	2,711	7,640				2.00
3.00	HMO IPF Subprovider	1,232	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,946	991	16,903			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
8.01	NEONATAL INTENSIVE CARE UNIT	0	19	569			8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	405	141	2,065			10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		51	586			13.00
14.00	Total (see instructions)	4,351	1,202	20,123	1.02	475.62	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	3,409	389	5,484	0.00	26.92	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	2,215	0	5,091	0.00	16.73	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	12			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)				1.02	519.27	27.00
28.00	Observation Bed Days		0	2,516			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			116			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	100	109			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: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 10/31/2018 1:09 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	799	2,016	4,547	1.00
2.00	HMO and other (see instructions)			492	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
8.01	NEONATAL INTENSIVE CARE UNIT						8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	799	2,016	4,547	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	107	390	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 10/31/2018 1:09 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	31,872,295	0	31,872,295	1,080,077.00	29.51	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	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,138,705	0	1,138,705	34,798.00	32.72	9.00
10.00	Excluded area salaries (see instructions)		1,399,163	0	1,399,163	56,000.00	24.99	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		508,341	0	508,341	7,350.00	69.16	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		100,790	0	100,790	761.00	132.44	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		2,650,566	0	2,650,566	82,705.00	32.05	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)		5,237,837	0	5,237,837			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		271,061	0	271,061			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)		0	0	0			25.00
25.50	Home office wage-related (core)		502,841	0	502,841			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	204,915	0	204,915	7,726.00	26.52	26.00
27.00	Administrative & General	5.00	3,726,455	-75,949	3,650,506	133,830.00	27.28	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-3 Part II | Date/Time Prepared: 10/31/2018 1:09 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	923,113	0	923,113	41,549.00	22.22	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	776,991	0	776,991	56,199.00	13.83	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		972,977	0	972,977	59,728.00	16.29	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,830,004	75,949	1,905,953	50,321.00	37.88	38.00
39.00	Central Services and Supply	14.00	299,789	0	299,789	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,510,272	0	1,510,272	34,601.00	43.65	40.00
41.00	Medical Records & Medical Records Library	16.00	108,303	0	108,303	8,380.00	12.92	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 10/31/2018 1:09 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		32,845,272	0	32,845,272	1,139,805.00	28.82	1.00
2.00	Excluded area salaries (see instructions)		2,537,868	0	2,537,868	90,798.00	27.95	2.00
3.00	Subtotal salaries (line 1 minus line 2)		30,307,404	0	30,307,404	1,049,007.00	28.89	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,259,697	0	3,259,697	90,816.00	35.89	4.00
5.00	Subtotal wage-related costs (see inst.)		5,740,678	0	5,740,678	0.00	18.94	5.00
6.00	Total (sum of lines 3 thru 5)		39,307,779	0	39,307,779	1,139,823.00	34.49	6.00
7.00	Total overhead cost (see instructions)		10,352,819	0	10,352,819	392,334.00	26.39	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 10/31/2018 1:09 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	556,144	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,152,459	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	21,984	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	22,046	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	664	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	6,277	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	391,124	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	1,831,684	17.00
18.00	Medicare Taxes - Employers Portion Only	428,378	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	98,140	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,508,900	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: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 10/31/2018 1:09 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	508,341	5,508,900	1.00
2.00	Hospital	508,341	5,508,900	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-7 | Date/Time Prepared: 10/31/2018 1:09 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	108	0	108	12.00
13.00		RUB	344	0	344	13.00
14.00		RUA	231	0	231	14.00
15.00		RVC	203	0	203	15.00
16.00		RVB	300	0	300	16.00
17.00		RVA	399	0	399	17.00
18.00		RHC	66	0	66	18.00
19.00		RHB	131	0	131	19.00
20.00		RHA	122	0	122	20.00
21.00		RMC	40	0	40	21.00
22.00		RMB	30	0	30	22.00
23.00		RMA	0	0	0	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	36	0	36	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	8	0	8	33.00
34.00		HC1	36	0	36	34.00
35.00		HB2	21	0	21	35.00
36.00		HB1	21	0	21	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	5	0	5	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	29	0	29	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	66	0	66	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-7 | Date/Time Prepared: 10/31/2018 1:09 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	3	0	3	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	16	0	16	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		2,215	0	2,215	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	23060	23060	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	4,099,060			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-10 | Date/Time Prepared: 10/31/2018 1:09 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.160222	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	24,273,943	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,886,724	5.00
6.00	Medicaid charges	166,990,054	6.00
7.00	Medicaid cost (line 1 times line 6)	26,755,480	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)	594,813	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)	292,717	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	3,322,607	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	532,355	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)	239,638	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)	834,451	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)	10,657,904	7,092	10,664,996	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,707,631	7,092	1,714,723	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	160	160	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,707,631	6,932	1,714,563	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	7,173,765	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	413,625	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	636,346	27.01
28.00	Non-Medicare bad debt expense (see instructions)	6,537,419	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,270,159	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,984,722	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,819,173	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A | Date/Time Prepared: 10/31/2018 1:09 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,018,257	2,018,257	1,117,853	3,136,110	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,229,634	3,229,634	1,235,967	4,465,601	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	204,915	91,040	295,955	3,239,318	3,535,273	4.00
5.01	00590	REVENUE CYCLE	1,875,829	3,511,344	5,387,173	-26,530	5,360,643	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	66,683	205,222	271,905	0	271,905	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	1,783,943	19,965,488	21,749,431	-4,462,510	17,286,921	5.03
7.00	00700	OPERATION OF PLANT	923,113	2,825,947	3,749,060	81,768	3,830,828	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	411,560	411,560	0	411,560	8.00
9.00	00900	HOUSEKEEPING	776,991	316,453	1,093,444	3,819	1,097,263	9.00
10.00	01000	DIETARY	0	2,050,096	2,050,096	-531,840	1,518,256	10.00
11.00	01100	CAFETERIA	0	0	0	530,020	530,020	11.00
13.00	01300	NURSING ADMINISTRATION	1,786,099	260,085	2,046,184	75,655	2,121,839	13.00
13.01	01301	PASTORAL CARE	43,905	14,746	58,651	0	58,651	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	299,789	5,622,928	5,922,717	-5,081,236	841,481	14.00
15.00	01500	PHARMACY	1,510,272	3,653,993	5,164,265	-3,784,035	1,380,230	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	108,303	518,076	626,379	-107	626,272	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	2,346,296	2,346,296	-2,346,296	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	2,346,296	2,346,296	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,079,186	2,481,466	9,560,652	-1,225,616	8,335,036	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	749,864	264,646	1,014,510	0	1,014,510	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	1,490,123	1,490,123	33.00
40.00	04000	SUBPROVIDER - IPF	1,399,163	959,705	2,358,868	0	2,358,868	40.00
43.00	04300	NURSERY	0	0	0	362,149	362,149	43.00
44.00	04400	SKILLED NURSING FACILITY	1,138,705	185,896	1,324,601	0	1,324,601	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,211,285	1,146,232	2,357,517	-4,149	2,353,368	50.00
51.00	05100	RECOVERY ROOM	335,487	86,655	422,142	-79	422,063	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	753,720	706,388	1,460,108	-628,537	831,571	52.00
53.00	05300	ANESTHESIOLOGY	0	1,152,007	1,152,007	0	1,152,007	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,145,886	1,069,969	2,215,855	796,940	3,012,795	54.00
54.01	03630	ULTRA SOUND	375,293	137,776	513,069	-513,069	0	54.01
56.00	05600	RADIOISOTOPE	90,929	157,302	248,231	-248,231	0	56.00
57.00	05700	CT SCAN	211,419	53,912	265,331	-265,331	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,720,284	1,720,284	59.00
60.00	06000	LABORATORY	2,012,120	1,798,346	3,810,466	-455,776	3,354,690	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	331,677	331,677	62.00
65.00	06500	RESPIRATORY THERAPY	587,439	162,146	749,585	0	749,585	65.00
66.00	06600	PHYSICAL THERAPY	439,668	98,404	538,072	-56,347	481,725	66.00
67.00	06700	OCCUPATIONAL THERAPY	336,347	28,463	364,810	0	364,810	67.00
68.00	06800	SPEECH PATHOLOGY	64,335	6,610	70,945	0	70,945	68.00
69.00	06900	ELECTROCARDIOLOGY	1,199,046	781,971	1,981,017	-1,720,284	260,733	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	936,063	936,063	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,575,093	3,575,093	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,507,865	3,507,865	73.00
74.00	07400	RENAL DIALYSIS	0	343,498	343,498	0	343,498	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	423,818	171,547	595,365	-172	595,193	76.02
76.03	03952	WOUND CARE	596,236	152,157	748,393	-645	747,748	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	42,479	19,034	61,513	0	61,513	90.00
91.00	09100	EMERGENCY	2,300,028	1,043,108	3,343,136	0	3,343,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,872,295	60,048,403	91,920,698	100	91,920,798	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	100	100	-100	0	192.00
194.00	07950	NONREIMBURSABLE MISC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.04	07954	FREE MEALS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	31,872,295	60,048,503	91,920,798	0	91,920,798	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A | Date/Time Prepared: 10/31/2018 1:09 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,591,783	5,727,893		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-855,416	3,610,185		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,180	3,532,093		4.00
5.01	00590	REVENUE CYCLE	-80,371	5,280,272		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	271,905		5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	-4,105,793	13,181,128		5.03
7.00	00700	OPERATION OF PLANT	-29,278	3,801,550		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-61,402	350,158		8.00
9.00	00900	HOUSEKEEPING	0	1,097,263		9.00
10.00	01000	DIETARY	0	1,518,256		10.00
11.00	01100	CAFETERIA	-10,593	519,427		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,121,839		13.00
13.01	01301	PASTORAL CARE	0	58,651		13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	841,481		14.00
15.00	01500	PHARMACY	0	1,380,230		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55	626,327		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	2,346,296		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,228,420	7,106,616		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	1,014,510		31.01
33.00	03300	BURN INTENSIVE CARE UNIT	0	1,490,123		33.00
40.00	04000	SUBPROVIDER - IPF	-771,302	1,587,566		40.00
43.00	04300	NURSERY	-64,821	297,328		43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,324,601		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-516,858	1,836,510		50.00
51.00	05100	RECOVERY ROOM	0	422,063		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-526,400	305,171		52.00
53.00	05300	ANESTHESIOLOGY	-1,151,804	203		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-10,650	3,002,145		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,720,284		59.00
60.00	06000	LABORATORY	-850	3,353,840		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	331,677		62.00
65.00	06500	RESPIRATORY THERAPY	0	749,585		65.00
66.00	06600	PHYSICAL THERAPY	0	481,725		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	364,810		67.00
68.00	06800	SPEECH PATHOLOGY	0	70,945		68.00
69.00	06900	ELECTROCARDIOLOGY	0	260,733		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	936,063		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,575,093		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,507,865		73.00
74.00	07400	RENAL DIALYSIS	0	343,498		74.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	595,193		76.02
76.03	03952	WOUND CARE	0	747,748		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-5,580	55,933		90.00
91.00	09100	EMERGENCY	-164,632	3,178,504		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,995,512	84,925,286		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	NONREIMBURSABLE MISC	0	0		194.00
194.01	07951	MARKETING	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0		194.02
194.04	07954	FREE MEALS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,995,512	84,925,286		200.00

RECLASSIFICATIONS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-6 | Date/Time Prepared: 10/31/2018 1:09 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,239,318	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	45	2.00
	0		0	3,239,363	
	B - OXYGEN				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,911	1.00
	0		0	1,911	
	C - LEASE AND RENTAL				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,224,218	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	0		0	1,224,218	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	114,210	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,003,643	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,749	3.00
	0		0	1,129,602	
	F - CNO				
1.00	NURSING ADMINISTRATION	13.00	75,949	0	1.00
	0		75,949	0	
	G - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	934,152	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,575,093	2.00
	0		0	4,509,245	
	H - DRUGS AND IV COSTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,507,865	1.00
	0		0	3,507,865	
	J - RADIOLOGY				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	677,641	348,990	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		677,641	348,990	
	K - DIETARY				
1.00	CAFETERIA	11.00	0	530,020	1.00
	0		0	530,020	
	L - MISC DEPARTMENTS				
1.00	BURN INTENSIVE CARE UNIT	33.00	1,172,534	317,589	1.00
2.00	CARDIAC CATHETERIZATION	59.00	960,707	759,577	2.00
3.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	331,677	3.00
	0		2,133,241	1,408,843	
	M - UTILITIES RECLASS				
1.00	OPERATION OF PLANT	7.00	0	84,031	1.00
2.00	HOUSEKEEPING	9.00	0	3,819	2.00
3.00		0.00	0	0	3.00
	0		0	87,850	
	N - INTERNS AND RESIDENT COSTS				
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	2,346,296	1.00
	0		0	2,346,296	
	O - OB/GYN COSTS				
1.00	ADULTS & PEDIATRICS	30.00	95,953	170,435	1.00
2.00	NURSERY	43.00	199,552	162,597	2.00
	0		295,505	333,032	
500.00	Grand Total: Increases		3,182,336	18,667,235	500.00

RECLASSIFICATIONS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-6 | Date/Time Prepared: 10/31/2018 1:09 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	3,239,363	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	3,239,363			
	B - OXYGEN						
1.00	OPERATION OF PLANT	7.00	0	1,911	0		1.00
	0		0	1,911			
	C - LEASE AND RENTAL						
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	16,834	10		1.00
2.00	OPERATION OF PLANT	7.00	0	352	0		2.00
3.00	DIETARY	10.00	0	1,820	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	294	0		4.00
5.00	PHARMACY	15.00	0	276,170	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	1,881	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	164,706	0		7.00
8.00	LABORATORY	60.00	0	124,099	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	56,347	0		9.00
10.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02	0	172	0		10.00
11.00	WOUND CARE	76.03	0	456	0		11.00
12.00	WOUND CARE	76.03	0	189	0		12.00
13.00	RECOVERY ROOM	51.00	0	79	0		13.00
14.00	MEDICAL RECORDS & LIBRARY	16.00	0	152	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	100	0		15.00
16.00	REVENUE CYCLE	5.01	0	4,427	0		16.00
17.00	CENTRAL SERVICES & SUPPLY	14.00	0	576,140	0		17.00
	0		0	1,224,218			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	1,129,602	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	1,129,602			
	F - CNO						
1.00	ADMINISTRATIVE AND GENERAL	5.03	75,949	0	0		1.00
	0		75,949	0			
	G - MEDICAL SUPPLIES						
1.00	OPERATING ROOM	50.00	0	4,149	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,505,096	0		2.00
	0		0	4,509,245			
	H - DRUGS AND IV COSTS						
1.00	PHARMACY	15.00	0	3,507,865	0		1.00
	0		0	3,507,865			
	J - RADIOLOGY						
1.00	ULTRA SOUND	54.01	375,293	137,776	0		1.00
2.00	RADIOISOTOPE	56.00	90,929	157,302	0		2.00
3.00	CT SCAN	57.00	211,419	53,912	0		3.00
	0		677,641	348,990			
	K - DIETARY						
1.00	DIETARY	10.00	0	530,020	0		1.00
	0		0	530,020			
	L - MISC DEPARTMENTS						
1.00	ADULTS & PEDIATRICS	30.00	1,172,534	317,589	0		1.00
2.00	LABORATORY	60.00	0	331,677	0		2.00
3.00	ELECTROCARDIOLOGY	69.00	960,707	759,577	0		3.00
	0		2,133,241	1,408,843			
	M - UTILITIES RECLASS						
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	762	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	64,985	0		2.00
3.00	REVENUE CYCLE	5.01	0	22,103	0		3.00
	0		0	87,850			
	N - INTERNS AND RESIDENT COSTS						
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	2,346,296	0		1.00
	0		0	2,346,296			
	O - OB/GYN COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	295,505	333,032	0		1.00
2.00		0.00	0	0	0		2.00
	0		295,505	333,032			
500.00	Grand Total: Decreases		3,182,336	18,667,235			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 10/31/2018 1:09 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	9,348,028	0	0	0	0	1.00
2.00	Land Improvements	1,764,690	11,145	0	11,145	0	2.00
3.00	Buildings and Fixtures	28,538,169	7,852	0	7,852	0	3.00
4.00	Building Improvements	30,171,661	296,405	0	296,405	2,534	4.00
5.00	Fixed Equipment	17,670,968	1,055,376	0	1,055,376	16,067	5.00
6.00	Movable Equipment	50,313,721	4,272,416	0	4,272,416	437,896	6.00
7.00	HIT designated Assets	2,833,813	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	140,641,050	5,643,194	0	5,643,194	456,497	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	140,641,050	5,643,194	0	5,643,194	456,497	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	9,348,028	0	1.00
2.00	Land Improvements	1,775,835	0	2.00
3.00	Buildings and Fixtures	28,546,021	0	3.00
4.00	Building Improvements	30,465,532	0	4.00
5.00	Fixed Equipment	18,710,277	0	5.00
6.00	Movable Equipment	54,148,241	0	6.00
7.00	HIT designated Assets	2,833,813	0	7.00
8.00	Subtotal (sum of lines 1-7)	145,827,747	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	145,827,747	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 10/31/2018 1:09 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,018,257	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,229,634	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,247,891	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,018,257		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,229,634		2.00
3.00	Total (sum of lines 1-2)	0	5,247,891		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 10/31/2018 1:09 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	70,135,416	0	70,135,416	0.480947	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	75,692,332	0	75,692,332	0.519053	0	2.00
3.00	Total (sum of lines 1-2)	145,827,748	0	145,827,748	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,327,584	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,374,218	1,224,218	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,701,802	1,224,218	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,282,456	114,210	1,003,643	0	5,727,893	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,749	0	0	3,610,185	2.00
3.00	Total (sum of lines 1-2)	1,282,456	125,959	1,003,643	0	9,338,078	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-8 | Date/Time Prepared: 10/31/2018 1:09 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-7,576	ADMINISTRATIVE AND GENERAL	5.03	0	7.00
8.00	Television and radio service (chapter 21)	A	-29,278	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,087,356			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-10,650	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	30,730			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-10,593	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	55	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	-1,255	ADMINISTRATIVE AND GENERAL	5.03	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	990,311	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-684,750	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	FITNESS REVENUE	B	-107,416	ADMINISTRATIVE AND GENERAL	5.03	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-8 | Date/Time Prepared: 10/31/2018 1:09 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MARKETING EXPENSE	A	-644,990	ADMINISTRATIVE AND GENERAL	5.03	0	33.01
33.04	NON RESTRICT DONATION	B	-1,380	ADMINISTRATIVE AND GENERAL	5.03	0	33.04
33.06	PATIENT PHONE WAGE COSTS	A	-18,105	ADMINISTRATIVE AND GENERAL	5.03	0	33.06
33.07	PATIENT PHONES BENEFITS	A	-3,180	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	PATIENT TV DEPRECIATION COSTS	A	-214	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	PATIENT TV DEPRECIATION	A	-5,211	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.11	PHYSICIAN RECRUITING	A	-132,367	ADMINISTRATIVE AND GENERAL	5.03	0	33.11
33.12	LOBBYING EXPENSE IN DUES	A	-1,937	ADMINISTRATIVE AND GENERAL	5.03	0	33.12
33.13	CHARITABLE CONTRIBUTIONS	A	-91,193	ADMINISTRATIVE AND GENERAL	5.03	0	33.13
33.15	IMPUTED RENT	A	-75,039	ADMINISTRATIVE AND GENERAL	5.03	0	33.15
33.16	NONALLOWABLE LEGAL EXPENSES	A	-104,118	ADMINISTRATIVE AND GENERAL	5.03	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,995,512				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: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 10/31/2018 1:09 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - CAPITAL-	1,262,032	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	15,957	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - MOVEABL	4,467	0	3.00
4.00	5.01	REVENUE CYCLE	PASI OPERATING COSTS	234,983	0	4.00
4.03	5.03	ADMINISTRATIVE AND GENERAL	SHARED SERVICE CENTER ALLOCA	1,302,823	1,013,566	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	44,102	0	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - MOVABLE EQUIPM	274,914	0	4.05
4.06	5.03	ADMINISTRATIVE AND GENERAL	NON-CAPITAL HOME OFFICE COST	2,549,226	0	4.06
4.07	5.03	ADMINISTRATIVE AND GENERAL	MALPRACTICE COSTS (SEE EXHIB	428,666	530,141	4.07
4.08	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT (SEE EX	114,929	0	4.08
4.09	8.00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICES (S	396,591	0	4.09
4.10	5.03	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	0	2,372,250	4.10
4.11	5.03	ADMINISTRATIVE AND GENERAL	401K FEES	0	6,128	4.11
4.12	5.03	ADMINISTRATIVE AND GENERAL	AUDIT FEES	0	49,194	4.12
4.13	5.03	ADMINISTRATIVE AND GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	1,106,596	4.13
4.14	5.03	ADMINISTRATIVE AND GENERAL	PPSI FEES	0	26,931	4.14
4.15	5.01	REVENUE CYCLE	PASI COLLECTION FEES	0	315,354	4.15
4.16	5.03	ADMINISTRATIVE AND GENERAL	CIG USE TAX	0	19,612	4.16
4.17	5.03	ADMINISTRATIVE AND GENERAL	PASI LIEN UNIT COLLECTION FE	0	42,375	4.17
4.18	5.03	ADMINISTRATIVE AND GENERAL	HIIM ALLOCATION	0	377,650	4.18
4.19	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT (PER EX	0	280,170	4.19
4.20	8.00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICES (P	0	457,993	4.20
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,628,690	6,597,960	5.00

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

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

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

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

6.00	B		0.00	CHS, INC	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00	C		33.00	SHARED LAUNDRY	33.00	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: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 10/31/2018 1:09 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,262,032	11		1.00
2.00	15,957	11		2.00
3.00	4,467	11		3.00
4.00	234,983	0		4.00
4.03	289,257	0		4.03
4.04	44,102	9		4.04
4.05	274,914	9		4.05
4.06	2,549,226	0		4.06
4.07	-101,475	0		4.07
4.08	114,929	9		4.08
4.09	396,591	0		4.09
4.10	-2,372,250	0		4.10
4.11	-6,128	0		4.11
4.12	-49,194	0		4.12
4.13	-1,106,596	0		4.13
4.14	-26,931	0		4.14
4.15	-315,354	0		4.15
4.16	-19,612	0		4.16
4.17	-42,375	0		4.17
4.18	-377,650	0		4.18
4.19	-280,170	9		4.19
4.20	-457,993	0		4.20
5.00	30,730			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	OWNER		6.00
7.00	DEBT COLLECTION		7.00
8.00	LAUNDRY		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: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 10/31/2018 1:09 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,228,420	1,228,420	0	0	0	1.00
2.00	43.00	NURSERY	64,821	64,821	0	0	0	2.00
3.00	5.03	ADMINISTRATIVE AND GENERAL	1,656,689	1,656,689	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	771,302	771,302	0	0	0	4.00
5.00	50.00	OPERATING ROOM	516,858	516,858	0	0	0	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	526,400	526,400	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	1,151,804	1,151,804	0	0	0	7.00
8.00	60.00	LABORATORY	850	850	0	0	0	8.00
9.00	90.00	CLINIC	5,580	5,580	0	0	0	9.00
10.00	91.00	EMERGENCY	164,632	164,632	0	0	0	10.00
11.00	33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	0	11.00
200.00			6,087,356	6,087,356	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	43.00	NURSERY	0	0	0	0	0	2.00
3.00	5.03	ADMINISTRATIVE AND GENERAL	0	0	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
11.00	33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	0	11.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,228,420		1.00
2.00	43.00	NURSERY	0	0	0	64,821		2.00
3.00	5.03	ADMINISTRATIVE AND GENERAL	0	0	0	1,656,689		3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	771,302		4.00
5.00	50.00	OPERATING ROOM	0	0	0	516,858		5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	526,400		6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	1,151,804		7.00
8.00	60.00	LABORATORY	0	0	0	850		8.00
9.00	90.00	CLINIC	0	0	0	5,580		9.00
10.00	91.00	EMERGENCY	0	0	0	164,632		10.00
11.00	33.00	BURN INTENSIVE CARE UNIT	0	0	0	0		11.00
200.00			0	0	0	6,087,356		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part I Date/Time Prepared: 10/31/2018 1:09 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	REVENUE CYCLE	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,727,893	5,727,893				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,610,185		3,610,185			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,532,093	64,831	40,862	3,637,786		4.00
5.01	00590	REVENUE CYCLE	5,280,272	229,965	144,943	215,486	5,870,666	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	271,905	159,721	100,669	7,660	0	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	13,181,128	124,263	78,321	196,206	0	5.03
7.00	00700	OPERATION OF PLANT	3,801,550	1,272,921	802,296	106,043	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	350,158	50,900	32,082	0	0	8.00
9.00	00900	HOUSEKEEPING	1,097,263	770,636	485,717	89,257	0	9.00
10.00	01000	DIETARY	1,518,256	240,736	151,732	0	0	10.00
11.00	01100	CAFETERIA	519,427	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,121,839	56,162	35,398	213,903	0	13.00
13.01	01301	PASTORAL CARE	58,651	32,038	20,193	5,044	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	841,481	0	0	34,438	0	14.00
15.00	01500	PHARMACY	1,380,230	0	0	173,492	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	626,327	144,252	90,919	12,441	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,346,296	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,106,616	512,589	323,076	689,544	572,870	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	1,014,510	206,734	130,301	86,141	24,077	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	1,490,123	96,347	60,726	134,695	163,071	33.00
40.00	04000	SUBPROVIDER - IPF	1,587,566	73,211	46,144	160,729	217,627	40.00
43.00	04300	NURSERY	297,328	0	0	22,924	8,241	43.00
44.00	04400	SKILLED NURSING FACILITY	1,324,601	134,731	84,919	130,809	47,631	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,836,510	236,038	148,770	139,146	501,250	50.00
51.00	05100	RECOVERY ROOM	422,063	88,543	55,807	38,539	33,392	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	305,171	78,789	49,659	52,637	18,922	52.00
53.00	05300	ANESTHESIOLOGY	203	0	0	0	69,303	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,002,145	226,435	142,718	209,478	853,898	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,720,284	25,224	15,898	110,361	265,468	59.00
60.00	06000	LABORATORY	3,353,840	193,806	122,152	231,142	683,304	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	331,677	10,620	6,693	0	33,845	62.00
65.00	06500	RESPIRATORY THERAPY	749,585	78,748	49,633	67,482	159,963	65.00
66.00	06600	PHYSICAL THERAPY	481,725	102,323	64,492	50,507	47,182	66.00
67.00	06700	OCCUPATIONAL THERAPY	364,810	39,168	24,687	38,638	47,172	67.00
68.00	06800	SPEECH PATHOLOGY	70,945	15,085	9,508	7,390	6,404	68.00
69.00	06900	ELECTROCARDIOLOGY	260,733	14,357	9,049	27,379	41,587	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	936,063	0	0	0	481,530	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,575,093	0	0	0	123,750	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,507,865	33,934	21,388	0	846,852	73.00
74.00	07400	RENAL DIALYSIS	343,498	27,614	17,405	0	17,483	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	595,193	44,759	28,211	48,686	35,679	76.02
76.03	03952	WOUND CARE	747,748	117,998	74,372	68,493	58,379	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	55,933	29,208	18,409	4,880	1,554	90.00
91.00	09100	EMERGENCY	3,178,504	181,304	114,273	264,216	510,232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,925,286	5,713,990	3,601,422	3,637,786	5,870,666	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,903	8,763	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE MISC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.04	07954	FREE MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part I Date/Time Prepared: 10/31/2018 1:09 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	REVENUE CYCLE	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01	
202.00	TOTAL (sum lines 118 through 201)	84,925,286	5,727,893	3,610,185	3,637,786	5,870,666	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part I | Date/Time Prepared: 10/31/2018 1:09 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	Subtotal	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	539,955					5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	1,291	13,581,209	13,581,209			5.03
7.00	00700	OPERATION OF PLANT	284	5,983,094	1,138,954	7,122,048		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,690	445,830	84,869	93,523	624,222	8.00
9.00	00900	HOUSEKEEPING	7,585	2,450,458	466,474	1,415,957	0	9.00
10.00	01000	DIETARY	8,353	1,919,077	365,319	442,325	0	10.00
11.00	01100	CAFETERIA	0	519,427	98,879	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	611	2,427,913	462,182	103,191	0	13.00
13.01	01301	PASTORAL CARE	30	115,956	22,074	58,866	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	875,919	166,742	0	0	14.00
15.00	01500	PHARMACY	9,312	1,563,034	297,542	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	216	874,155	166,406	265,046	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	2,346,296	446,646	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,461	9,226,156	1,756,316	941,823	239,338	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	2,317	1,464,080	278,705	379,849	1,126	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	8,461	1,953,423	371,858	177,026	41,506	33.00
40.00	04000	SUBPROVIDER - IPF	2,958	2,088,235	397,521	134,517	36,397	40.00
43.00	04300	NURSERY	0	328,493	62,533	0	2,191	43.00
44.00	04400	SKILLED NURSING FACILITY	3,251	1,725,942	328,554	247,553	47,492	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,108	2,903,822	552,777	433,692	46,254	50.00
51.00	05100	RECOVERY ROOM	21	638,365	121,520	162,688	12,082	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,641	508,819	96,860	144,766	0	52.00
53.00	05300	ANESTHESIOLOGY	10	69,516	13,233	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,041	4,443,715	845,914	416,047	31,411	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	20,188	2,157,423	410,691	46,345	15,528	59.00
60.00	06000	LABORATORY	40,013	4,624,257	880,283	356,096	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	20,815	403,650	76,840	19,512	0	62.00
65.00	06500	RESPIRATORY THERAPY	7,125	1,112,536	211,785	144,690	0	65.00
66.00	06600	PHYSICAL THERAPY	470	746,699	142,143	188,006	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	70	514,545	97,950	71,966	0	67.00
68.00	06800	SPEECH PATHOLOGY	80	109,412	20,828	27,716	0	68.00
69.00	06900	ELECTROCARDIOLOGY	242	353,347	67,264	26,378	2,379	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,707	1,472,300	280,270	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	230,627	3,929,470	748,022	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,410,039	839,504	62,349	0	73.00
74.00	07400	RENAL DIALYSIS	321	406,321	77,348	50,737	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	311	752,839	143,312	82,240	0	76.02
76.03	03952	WOUND CARE	6,272	1,073,262	204,308	216,808	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	109,984	20,937	53,666	16,148	90.00
91.00	09100	EMERGENCY	25,073	4,273,602	813,531	333,125	132,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	539,955	84,902,620	13,576,894	7,096,503	624,222	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,666	4,315	25,545	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE MISC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.04	07954	FREE MEALS	0	0	0	0	0	194.04
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)	539,955	84,925,286	13,581,209	7,122,048	624,222	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part I Date/Time Prepared: 10/31/2018 1:09 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PASTORAL CARE	
			9.00	10.00	11.00	13.00	13.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	4,332,889					9.00
10.00	01000	DIETARY	341,473	3,068,194				10.00
11.00	01100	CAFETERIA	0	0	618,306			11.00
13.00	01300	NURSING ADMINISTRATION	79,663	0	35,439	3,108,388		13.00
13.01	01301	PASTORAL CARE	45,444	0	1,560	0	243,900	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	11,930	0	0	14.00
15.00	01500	PHARMACY	0	0	25,451	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	204,615	0	6,164	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	727,086	1,121,303	147,949	1,261,606	98,996	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	293,243	0	14,270	157,603	12,366	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	136,663	138,112	24,916	246,439	19,336	33.00
40.00	04000	SUBPROVIDER - IPF	103,847	359,624	41,175	294,070	23,074	40.00
43.00	04300	NURSERY	0	0	3,701	41,941	3,291	43.00
44.00	04400	SKILLED NURSING FACILITY	191,110	333,846	25,589	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	334,809	0	26,919	254,583	19,975	50.00
51.00	05100	RECOVERY ROOM	125,595	0	6,608	70,511	5,533	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	111,759	0	8,504	96,306	7,556	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	321,187	0	45,947	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	35,778	0	17,651	201,918	15,843	59.00
60.00	06000	LABORATORY	274,905	0	54,099	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	15,064	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	111,700	0	14,010	0	0	65.00
66.00	06600	PHYSICAL THERAPY	145,140	0	8,856	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	55,558	0	5,965	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	21,397	0	1,055	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	20,364	0	8,688	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,133	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	39,169	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	63,489	0	13,337	0	0	76.02
76.03	03952	WOUND CARE	167,375	0	14,408	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	41,430	0	1,071	0	0	90.00
91.00	09100	EMERGENCY	257,172	0	53,044	483,411	37,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,313,168	1,952,885	618,306	3,108,388	243,900	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,721	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	788,855	0	0	0	192.00
194.00	07950	NONREIMBURSABLE MISC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.04	07954	FREE MEALS	0	326,454	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,332,889	3,068,194	618,306	3,108,388	243,900	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part I | Date/Time Prepared: 10/31/2018 1:09 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	
			14.00	15.00	16.00	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
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
13.01	01301	PASTORAL CARE						13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	1,054,591					14.00
15.00	01500	PHARMACY	19,288	1,905,315				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	447	0	1,516,833			16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		2,792,942	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	44,455	0	148,000	0	997,480	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	4,799	0	6,220	0	0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	17,526	0	42,129	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	6,127	0	56,223	0	0	40.00
43.00	04300	NURSERY	0	0	2,129	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,735	0	12,305	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	87,223	0	129,497	0	797,983	50.00
51.00	05100	RECOVERY ROOM	44	0	8,627	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,541	0	4,889	0	0	52.00
53.00	05300	ANESTHESIOLOGY	22	0	17,904	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,727	0	220,763	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	41,817	0	68,583	0	0	59.00
60.00	06000	LABORATORY	82,883	0	176,530	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	43,117	0	8,744	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	14,759	0	41,326	0	0	65.00
66.00	06600	PHYSICAL THERAPY	973	0	12,189	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	145	0	12,187	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	165	0	1,654	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	501	0	10,744	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	113,320	0	124,402	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	477,740	0	31,970	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,905,315	218,782	0	0	73.00
74.00	07400	RENAL DIALYSIS	664	0	4,517	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	644	0	9,218	0	0	76.02
76.03	03952	WOUND CARE	12,992	0	15,082	0	997,479	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	402	0	0	90.00
91.00	09100	EMERGENCY	51,937	0	131,817	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,054,591	1,905,315	1,516,833	0	2,792,942	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE MISC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.04	07954	FREE MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,054,591	1,905,315	1,516,833	0	2,792,942	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part I | Date/Time Prepared: 10/31/2018 1:09 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	REVENUE CYCLE					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00591	ADMINISTRATIVE AND GENERAL					5.03
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
13.01	01301	PASTORAL CARE					13.01
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	16,710,508	-997,480	15,713,028		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	2,612,261	0	2,612,261		31.01
33.00	03300	BURN INTENSIVE CARE UNIT	3,168,934	0	3,168,934		33.00
40.00	04000	SUBPROVIDER - IPF	3,540,810	0	3,540,810		40.00
43.00	04300	NURSERY	444,279	0	444,279		43.00
44.00	04400	SKILLED NURSING FACILITY	2,919,126	0	2,919,126		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,587,534	-797,983	4,789,551		50.00
51.00	05100	RECOVERY ROOM	1,151,573	0	1,151,573		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	987,000	0	987,000		52.00
53.00	05300	ANESTHESIOLOGY	100,675	0	100,675		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,343,711	0	6,343,711		54.00
54.01	03630	ULTRA SOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	3,011,577	0	3,011,577		59.00
60.00	06000	LABORATORY	6,449,053	0	6,449,053		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	566,927	0	566,927		62.00
65.00	06500	RESPIRATORY THERAPY	1,650,806	0	1,650,806		65.00
66.00	06600	PHYSICAL THERAPY	1,244,006	0	1,244,006		66.00
67.00	06700	OCCUPATIONAL THERAPY	758,316	0	758,316		67.00
68.00	06800	SPEECH PATHOLOGY	182,227	0	182,227		68.00
69.00	06900	ELECTROCARDIOLOGY	489,665	0	489,665		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,990,292	0	1,990,292		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,187,202	0	5,187,202		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,484,122	0	7,484,122		73.00
74.00	07400	RENAL DIALYSIS	578,756	0	578,756		74.00
76.00	03950	MISC ANCILLARY	0	0	0		76.00
76.01	03951	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,065,079	0	1,065,079		76.02
76.03	03952	WOUND CARE	2,701,714	-997,479	1,704,235		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	243,638	0	243,638		90.00
91.00	09100	EMERGENCY	6,567,939	0	6,567,939		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,737,730	-2,792,942	80,944,788		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	72,247	0	72,247		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	788,855	0	788,855		192.00
194.00	07950	NONREIMBURSABLE MISC	0	0	0		194.00
194.01	07951	MARKETING	0	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0	0		194.02
194.04	07954	FREE MEALS	326,454	0	326,454		194.04
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)	84,925,286	-2,792,942	82,132,344		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part II Date/Time Prepared: 10/31/2018 1:09 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	64,831	40,862	105,693	105,693	4.00
5.01	00590	REVENUE CYCLE	0	229,965	144,943	374,908	6,262	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	159,721	100,669	260,390	223	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	0	124,263	78,321	202,584	5,701	5.03
7.00	00700	OPERATION OF PLANT	0	1,272,921	802,296	2,075,217	3,081	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	50,900	32,082	82,982	0	8.00
9.00	00900	HOUSEKEEPING	0	770,636	485,717	1,256,353	2,594	9.00
10.00	01000	DIETARY	0	240,736	151,732	392,468	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	56,162	35,398	91,560	6,216	13.00
13.01	01301	PASTORAL CARE	0	32,038	20,193	52,231	147	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	1,001	14.00
15.00	01500	PHARMACY	0	0	0	0	5,041	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	144,252	90,919	235,171	362	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	512,589	323,076	835,665	20,021	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	206,734	130,301	337,035	2,503	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	0	96,347	60,726	157,073	3,914	33.00
40.00	04000	SUBPROVIDER - IPF	0	73,211	46,144	119,355	4,670	40.00
43.00	04300	NURSERY	0	0	0	0	666	43.00
44.00	04400	SKILLED NURSING FACILITY	0	134,731	84,919	219,650	3,801	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	236,038	148,770	384,808	4,043	50.00
51.00	05100	RECOVERY ROOM	0	88,543	55,807	144,350	1,120	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	78,789	49,659	128,448	1,530	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	226,435	142,718	369,153	6,087	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	25,224	15,898	41,122	3,207	59.00
60.00	06000	LABORATORY	0	193,806	122,152	315,958	6,716	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	10,620	6,693	17,313	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	78,748	49,633	128,381	1,961	65.00
66.00	06600	PHYSICAL THERAPY	0	102,323	64,492	166,815	1,468	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	39,168	24,687	63,855	1,123	67.00
68.00	06800	SPEECH PATHOLOGY	0	15,085	9,508	24,593	215	68.00
69.00	06900	ELECTROCARDIOLOGY	0	14,357	9,049	23,406	796	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	33,934	21,388	55,322	0	73.00
74.00	07400	RENAL DIALYSIS	0	27,614	17,405	45,019	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	44,759	28,211	72,970	1,415	76.02
76.03	03952	WOUND CARE	0	117,998	74,372	192,370	1,990	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	29,208	18,409	47,617	142	90.00
91.00	09100	EMERGENCY	0	181,304	114,273	295,577	7,677	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,713,990	3,601,422	9,315,412	105,693	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,903	8,763	22,666	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE MISC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.04	07954	FREE MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,727,893	3,610,185	9,338,078	105,693	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part II | Date/Time Prepared: 10/31/2018 1:09 pm

		Cost Center Description	REVENUE CYCLE	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE	381,170					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	260,613				5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	0	623	208,908			5.03
7.00	00700	OPERATION OF PLANT	0	137	17,518	2,095,953		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,125	1,305	27,523	117,935	8.00
9.00	00900	HOUSEKEEPING	0	3,661	7,175	416,700	0	9.00
10.00	01000	DIETARY	0	4,031	5,619	130,172	0	10.00
11.00	01100	CAFETERIA	0	0	1,521	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	295	7,109	30,368	0	13.00
13.01	01301	PASTORAL CARE	0	15	340	17,324	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,565	0	0	14.00
15.00	01500	PHARMACY	0	4,494	4,577	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	104	2,560	78,001	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	6,870	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,172	10,358	27,024	277,170	45,216	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	1,562	1,118	4,287	111,786	213	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	10,581	4,084	5,720	52,097	7,842	33.00
40.00	04000	SUBPROVIDER - IPF	14,121	1,428	6,114	39,587	6,877	40.00
43.00	04300	NURSERY	535	0	962	0	414	43.00
44.00	04400	SKILLED NURSING FACILITY	3,091	1,569	5,054	72,853	8,973	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,525	20,324	8,502	127,631	8,739	50.00
51.00	05100	RECOVERY ROOM	2,167	10	1,869	47,878	2,283	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,228	1,757	1,490	42,603	0	52.00
53.00	05300	ANESTHESIOLOGY	4,497	5	204	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,641	4,364	13,011	122,439	5,934	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,226	9,744	6,317	13,639	2,934	59.00
60.00	06000	LABORATORY	44,338	19,312	13,540	104,796	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,196	10,047	1,182	5,742	0	62.00
65.00	06500	RESPIRATORY THERAPY	10,380	3,439	3,258	42,581	0	65.00
66.00	06600	PHYSICAL THERAPY	3,062	227	2,186	55,328	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,061	34	1,507	21,179	0	67.00
68.00	06800	SPEECH PATHOLOGY	416	38	320	8,157	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,698	117	1,035	7,763	450	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,246	26,404	4,311	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,030	111,315	11,505	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	54,951	0	12,913	18,349	0	73.00
74.00	07400	RENAL DIALYSIS	1,134	155	1,190	14,932	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,315	150	2,204	24,203	0	76.02
76.03	03952	WOUND CARE	3,788	3,027	3,143	63,805	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	101	0	322	15,793	3,051	90.00
91.00	09100	EMERGENCY	33,108	12,102	12,513	98,036	25,009	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	381,170	260,613	208,842	2,088,435	117,935	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	66	7,518	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE MISC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.04	07954	FREE MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	381,170	260,613	208,908	2,095,953	117,935	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part II Date/Time Prepared: 10/31/2018 1:09 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PASTORAL CARE	
			9.00	10.00	11.00	13.00	13.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	1,686,483					9.00
10.00	01000	DIETARY	132,911	665,201				10.00
11.00	01100	CAFETERIA	0	0	1,521			11.00
13.00	01300	NURSING ADMINISTRATION	31,007	0	87	166,642		13.00
13.01	01301	PASTORAL CARE	17,688	0	4	0	87,749	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	29	0	0	14.00
15.00	01500	PHARMACY	0	0	63	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	79,642	0	15	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	283,001	243,104	366	67,632	35,616	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	114,138	0	35	8,449	4,449	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	53,193	29,943	61	13,212	6,957	33.00
40.00	04000	SUBPROVIDER - IPF	40,420	77,969	101	15,766	8,301	40.00
43.00	04300	NURSERY	0	0	9	2,249	1,184	43.00
44.00	04400	SKILLED NURSING FACILITY	74,386	72,380	63	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	130,317	0	66	13,649	7,187	50.00
51.00	05100	RECOVERY ROOM	48,885	0	16	3,780	1,990	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	43,500	0	21	5,163	2,719	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	125,015	0	113	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,926	0	43	10,825	5,700	59.00
60.00	06000	LABORATORY	107,001	0	133	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,863	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	43,477	0	34	0	0	65.00
66.00	06600	PHYSICAL THERAPY	56,493	0	22	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,625	0	15	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,328	0	3	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,926	0	21	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,735	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	15,246	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	24,712	0	33	0	0	76.02
76.03	03952	WOUND CARE	65,147	0	35	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	16,126	0	3	0	0	90.00
91.00	09100	EMERGENCY	100,099	0	130	25,917	13,646	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,678,807	423,396	1,521	166,642	87,749	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,676	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	171,028	0	0	0	192.00
194.00	07950	NONREIMBURSABLE MISC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.04	07954	FREE MEALS	0	70,777	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,686,483	665,201	1,521	166,642	87,749	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part II Date/Time Prepared: 10/31/2018 1:09 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	
			14.00	15.00	16.00	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
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
13.01	01301	PASTORAL CARE						13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	3,595					14.00
15.00	01500	PHARMACY	66	14,241				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2	0	395,857			16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		6,870	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	152	0	38,651			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0			31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	16	0	1,624			31.01
33.00	03300	BURN INTENSIVE CARE UNIT	60	0	11,002			33.00
40.00	04000	SUBPROVIDER - IPF	21	0	14,683			40.00
43.00	04300	NURSERY	0	0	556			43.00
44.00	04400	SKILLED NURSING FACILITY	23	0	3,214			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	297	0	33,819			50.00
51.00	05100	RECOVERY ROOM	0	0	2,253			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26	0	1,277			52.00
53.00	05300	ANESTHESIOLOGY	0	0	4,676			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64	0	57,378			54.00
54.01	03630	ULTRA SOUND	0	0	0			54.01
56.00	05600	RADIOISOTOPE	0	0	0			56.00
57.00	05700	CT SCAN	0	0	0			57.00
58.00	05800	MRI	0	0	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	143	0	17,911			59.00
60.00	06000	LABORATORY	283	0	46,102			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	147	0	2,283			62.00
65.00	06500	RESPIRATORY THERAPY	50	0	10,793			65.00
66.00	06600	PHYSICAL THERAPY	3	0	3,183			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,183			67.00
68.00	06800	SPEECH PATHOLOGY	1	0	432			68.00
69.00	06900	ELECTROCARDIOLOGY	2	0	2,806			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	386	0	32,489			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,628	0	8,349			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,241	57,137			73.00
74.00	07400	RENAL DIALYSIS	2	0	1,180			74.00
76.00	03950	MISC ANCILLARY	0	0	0			76.00
76.01	03951	SLEEP LAB	0	0	0			76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2	0	2,407			76.02
76.03	03952	WOUND CARE	44	0	3,939			76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	105			90.00
91.00	09100	EMERGENCY	177	0	34,425			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,595	14,241	395,857	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
191.00	19100	RESEARCH	0	0	0			191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
194.00	07950	NONREIMBURSABLE MISC	0	0	0			194.00
194.01	07951	MARKETING	0	0	0			194.01
194.02	07952	SENIOR CIRCLE	0	0	0			194.02
194.04	07954	FREE MEALS	0	0	0			194.04
200.00		Cross Foot Adjustments				0	6,870	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,595	14,241	395,857	0	6,870	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part II | Date/Time Prepared: 10/31/2018 1:09 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	REVENUE CYCLE					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00591	ADMINISTRATIVE AND GENERAL					5.03
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
13.01	01301	PASTORAL CARE					13.01
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,921,148	0	1,921,148		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	587,215	0	587,215		31.01
33.00	03300	BURN INTENSIVE CARE UNIT	355,739	0	355,739		33.00
40.00	04000	SUBPROVIDER - IPF	349,413	0	349,413		40.00
43.00	04300	NURSERY	6,575	0	6,575		43.00
44.00	04400	SKILLED NURSING FACILITY	465,057	0	465,057		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	771,907	0	771,907		50.00
51.00	05100	RECOVERY ROOM	256,601	0	256,601		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	229,762	0	229,762		52.00
53.00	05300	ANESTHESIOLOGY	9,382	0	9,382		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	759,199	0	759,199		54.00
54.01	03630	ULTRA SOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	142,737	0	142,737		59.00
60.00	06000	LABORATORY	658,179	0	658,179		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	44,773	0	44,773		62.00
65.00	06500	RESPIRATORY THERAPY	244,354	0	244,354		65.00
66.00	06600	PHYSICAL THERAPY	288,787	0	288,787		66.00
67.00	06700	OCCUPATIONAL THERAPY	115,582	0	115,582		67.00
68.00	06800	SPEECH PATHOLOGY	42,503	0	42,503		68.00
69.00	06900	ELECTROCARDIOLOGY	47,020	0	47,020		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	94,836	0	94,836		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	140,827	0	140,827		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	231,648	0	231,648		73.00
74.00	07400	RENAL DIALYSIS	78,858	0	78,858		74.00
76.00	03950	MISC ANCILLARY	0	0	0		76.00
76.01	03951	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	130,411	0	130,411		76.02
76.03	03952	WOUND CARE	337,288	0	337,288		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	83,260	0	83,260		90.00
91.00	09100	EMERGENCY	658,416	0	658,416		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,051,477	0	9,051,477		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37,926	0	37,926		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	171,028	0	171,028		192.00
194.00	07950	NONREIMBURSABLE MISC	0	0	0		194.00
194.01	07951	MARKETING	0	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0	0		194.02
194.04	07954	FREE MEALS	70,777	0	70,777		194.04
200.00		Cross Foot Adjustments	6,870	0	6,870		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	9,338,078	0	9,338,078		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B-1 | Date/Time Prepared: 10/31/2018 1:09 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FOO TAGE)	MVBLE EQUIP (SQUARE FOO TAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	REVENUE CYCLE (GROSS CHAR GES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	416,929					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		416,929				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,719	4,719	31,667,380			4.00
5.01	00590	REVENUE CYCLE	16,739	16,739	1,875,829	505,205,399		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	11,626	11,626	66,683	0	8,532,990	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	9,045	9,045	1,707,994	0	20,407	5.03
7.00	00700	OPERATION OF PLANT	92,655	92,655	923,113	0	4,482	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,705	3,705	0	0	200,541	8.00
9.00	00900	HOUSEKEEPING	56,094	56,094	776,991	0	119,867	9.00
10.00	01000	DIETARY	17,523	17,523	0	0	131,998	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,088	4,088	1,862,048	0	9,655	13.00
13.01	01301	PASTORAL CARE	2,332	2,332	43,905	0	478	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	299,789	0	0	14.00
15.00	01500	PHARMACY	0	0	1,510,272	0	147,152	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,500	10,500	108,303	0	3,407	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,311	37,311	6,002,605	49,300,306	339,152	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	15,048	15,048	749,864	2,072,063	36,611	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	7,013	7,013	1,172,534	14,033,621	133,704	33.00
40.00	04000	SUBPROVIDER - IPF	5,329	5,329	1,399,163	18,728,652	46,745	40.00
43.00	04300	NURSERY	0	0	199,552	709,186	0	43.00
44.00	04400	SKILLED NURSING FACILITY	9,807	9,807	1,138,705	4,099,060	51,382	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,181	17,181	1,211,285	43,136,860	665,432	50.00
51.00	05100	RECOVERY ROOM	6,445	6,445	335,487	2,873,703	337	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,735	5,735	458,215	1,628,441	57,531	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,964,129	165	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,482	16,482	1,823,527	73,469,768	142,871	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,836	1,836	960,707	22,845,742	319,027	59.00
60.00	06000	LABORATORY	14,107	14,107	2,012,120	58,804,110	632,324	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	773	773	0	2,912,610	328,947	62.00
65.00	06500	RESPIRATORY THERAPY	5,732	5,732	587,439	13,766,218	112,599	65.00
66.00	06600	PHYSICAL THERAPY	7,448	7,448	439,668	4,060,382	7,422	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,851	2,851	336,347	4,059,510	1,103	67.00
68.00	06800	SPEECH PATHOLOGY	1,098	1,098	64,335	551,125	1,257	68.00
69.00	06900	ELECTROCARDIOLOGY	1,045	1,045	238,339	3,578,875	3,821	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	41,439,798	864,529	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,649,725	3,644,716	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,470	2,470	0	72,878,844	0	73.00
74.00	07400	RENAL DIALYSIS	2,010	2,010	0	1,504,604	5,068	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,258	3,258	423,818	3,070,472	4,912	76.02
76.03	03952	WOUND CARE	8,589	8,589	596,236	5,024,050	99,114	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,126	2,126	42,479	133,763	0	90.00
91.00	09100	EMERGENCY	13,197	13,197	2,300,028	43,909,782	396,234	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	415,917	415,917	31,667,380	505,205,399	8,532,990	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,012	1,012	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE MISC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.04	07954	FREE MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B-1 | Date/Time Prepared: 10/31/2018 1:09 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FOOTAGE)	MVBLE EQUIP (SQUARE FOOTAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	REVENUE CYCLE (GROSS CHARGES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
		1.00	2.00	4.00	5.01	5.02	
202.00	Cost to be allocated (per Wkst. B, Part I)	5,727,893	3,610,185	3,637,786	5,870,666	539,955	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	13.738294	8.658992	0.114875	0.011620	0.063279	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			105,693	381,170	260,613	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.003338	0.000754	0.030542	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: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B-1 | Date/Time Prepared: 10/31/2018 1:09 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM.COST)	OPERATION OF PLANT (SQUARE FOOTAGE)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FOOTAGE)	
			5A.03	5.03	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	-13,581,209	71,344,077				5.03
7.00	00700	OPERATION OF PLANT	0	5,983,094	282,145			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	445,830	3,705	784,437		8.00
9.00	00900	HOUSEKEEPING	0	2,450,458	56,094	0	222,346	9.00
10.00	01000	DIETARY	0	1,919,077	17,523	0	17,523	10.00
11.00	01100	CAFETERIA	0	519,427	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,427,913	4,088	0	4,088	13.00
13.01	01301	PASTORAL CARE	0	115,956	2,332	0	2,332	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	875,919	0	0	0	14.00
15.00	01500	PHARMACY	0	1,563,034	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	874,155	10,500	0	10,500	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	2,346,296	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	9,226,156	37,311	300,767	37,311	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	1,464,080	15,048	1,415	15,048	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	0	1,953,423	7,013	52,159	7,013	33.00
40.00	04000	SUBPROVIDER - IPF	0	2,088,235	5,329	45,739	5,329	40.00
43.00	04300	NURSERY	0	328,493	0	2,753	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,725,942	9,807	59,682	9,807	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,903,822	17,181	58,126	17,181	50.00
51.00	05100	RECOVERY ROOM	0	638,365	6,445	15,183	6,445	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	508,819	5,735	0	5,735	52.00
53.00	05300	ANESTHESIOLOGY	0	69,516	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,443,715	16,482	39,473	16,482	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,157,423	1,836	19,514	1,836	59.00
60.00	06000	LABORATORY	0	4,624,257	14,107	0	14,107	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	403,650	773	0	773	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,112,536	5,732	0	5,732	65.00
66.00	06600	PHYSICAL THERAPY	0	746,699	7,448	0	7,448	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	514,545	2,851	0	2,851	67.00
68.00	06800	SPEECH PATHOLOGY	0	109,412	1,098	0	1,098	68.00
69.00	06900	ELECTROCARDIOLOGY	0	353,347	1,045	2,990	1,045	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,472,300	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,929,470	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,410,039	2,470	0	2,470	73.00
74.00	07400	RENAL DIALYSIS	0	406,321	2,010	0	2,010	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	752,839	3,258	0	3,258	76.02
76.03	03952	WOUND CARE	0	1,073,262	8,589	0	8,589	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	109,984	2,126	20,292	2,126	90.00
91.00	09100	EMERGENCY	0	4,273,602	13,197	166,344	13,197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,581,209	71,321,411	281,133	784,437	221,334	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,666	1,012	0	1,012	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE MISC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.04	07954	FREE MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		13,581,209	7,122,048	624,222	4,332,889	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.190362	25.242510	0.795758	19.487146	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B-1 | Date/Time Prepared: 10/31/2018 1:09 pm

	Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM.COST)	OPERATION OF PLANT (SQUARE FOO TAGE)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FOO TAGE)	
		5A.03	5.03	7.00	8.00	9.00	
204.00	Cost to be allocated (per Wkst. B, Part II)		208,908	2,095,953	117,935	1,686,483	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.002928	7.428638	0.150343	7.584949	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: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B-1 | Date/Time Prepared: 10/31/2018 1:09 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (GROSS SALARIES)	PASTORAL CARE (GROSS SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			10.00	11.00	13.00	13.01	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
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	164,371					10.00
11.00	01100	CAFETERIA	0	40,425				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,317	14,789,440			13.00
13.01	01301	PASTORAL CARE	0	102	0	14,789,440		13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	780	0	0	8,045,562	14.00
15.00	01500	PHARMACY	0	1,664	0	0	147,152	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	403	0	0	3,407	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	60,071	9,673	6,002,605	6,002,605	339,152	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	933	749,864	749,864	36,611	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	7,399	1,629	1,172,534	1,172,534	133,704	33.00
40.00	04000	SUBPROVIDER - IPF	19,266	2,692	1,399,163	1,399,163	46,745	40.00
43.00	04300	NURSERY	0	242	199,552	199,552	0	43.00
44.00	04400	SKILLED NURSING FACILITY	17,885	1,673	0	0	51,382	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,760	1,211,285	1,211,285	665,432	50.00
51.00	05100	RECOVERY ROOM	0	432	335,487	335,487	337	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	556	458,215	458,215	57,531	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	165	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,004	0	0	142,871	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,154	960,707	960,707	319,027	59.00
60.00	06000	LABORATORY	0	3,537	0	0	632,324	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	328,947	62.00
65.00	06500	RESPIRATORY THERAPY	0	916	0	0	112,599	65.00
66.00	06600	PHYSICAL THERAPY	0	579	0	0	7,422	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	390	0	0	1,103	67.00
68.00	06800	SPEECH PATHOLOGY	0	69	0	0	1,257	68.00
69.00	06900	ELECTROCARDIOLOGY	0	568	0	0	3,821	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	864,529	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,644,716	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	5,068	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	872	0	0	4,912	76.02
76.03	03952	WOUND CARE	0	942	0	0	99,114	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	70	0	0	0	90.00
91.00	09100	EMERGENCY	0	3,468	2,300,028	2,300,028	396,234	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	104,621	40,425	14,789,440	14,789,440	8,045,562	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	42,261	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE MISC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.04	07954	FREE MEALS	17,489	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,068,194	618,306	3,108,388	243,900	1,054,591	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B-1 | Date/Time Prepared: 10/31/2018 1:09 pm

	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (GROSS SALARIES)	PASTORAL CARE (GROSS SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		10.00	11.00	13.00	13.01	14.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	18.666273	15.295139	0.210176	0.016491	0.131077	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	665,201	1,521	166,642	87,749	3,595	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.046949	0.037625	0.011268	0.005933	0.000447	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: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B-1 | Date/Time Prepared: 10/31/2018 1:09 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ROTATIONS)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ROTATIONS)		
			15.00	16.00	21.00	22.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
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
13.01	01301	PASTORAL CARE						13.01
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	3,215,737					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	505,205,399				16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,400			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		1,400		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	49,300,306	500	500		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	2,072,063	0	0		31.01
33.00	03300	BURN INTENSIVE CARE UNIT	0	14,033,621	0	0		33.00
40.00	04000	SUBPROVIDER - IPF	0	18,728,652	0	0		40.00
43.00	04300	NURSERY	0	709,186	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	4,099,060	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	43,136,860	400	400		50.00
51.00	05100	RECOVERY ROOM	0	2,873,703	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,628,441	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	5,964,129	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	73,469,768	0	0		54.00
54.01	03630	ULTRA SOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	22,845,742	0	0		59.00
60.00	06000	LABORATORY	0	58,804,110	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,912,610	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	13,766,218	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	4,060,382	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,059,510	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	551,125	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,578,875	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	41,439,798	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,649,725	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,215,737	72,878,844	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	1,504,604	0	0		74.00
76.00	03950	MISC ANCILLARY	0	0	0	0		76.00
76.01	03951	SLEEP LAB	0	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	3,070,472	0	0		76.02
76.03	03952	WOUND CARE	0	5,024,050	500	500		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	133,763	0	0		90.00
91.00	09100	EMERGENCY	0	43,909,782	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,215,737	505,205,399	1,400	1,400		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	NONREIMBURSABLE MISC	0	0	0	0		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0		194.02
194.04	07954	FREE MEALS	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B-1 | Date/Time Prepared: 10/31/2018 1:09 pm

	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ROTATIONS)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ROTATIONS)		
		15.00	16.00	21.00	22.00		
202.00	Cost to be allocated (per Wkst. B, Part I)	1,905,315	1,516,833	0	2,792,942		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.592497	0.003002	0.000000	1,994.958571		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	14,241	395,857	0	6,870		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.004429	0.000784	0.000000	4.907143		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet C Part I Date/Time Prepared: 10/31/2018 1:09 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,713,028		15,713,028	0	15,713,028	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	2,612,261		2,612,261	0	2,612,261	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	3,168,934		3,168,934	0	3,168,934	33.00
40.00	04000	SUBPROVIDER - IPF	3,540,810		3,540,810	0	3,540,810	40.00
43.00	04300	NURSERY	444,279		444,279	0	444,279	43.00
44.00	04400	SKILLED NURSING FACILITY	2,919,126		2,919,126	0	2,919,126	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,789,551		4,789,551	0	4,789,551	50.00
51.00	05100	RECOVERY ROOM	1,151,573		1,151,573	0	1,151,573	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	987,000		987,000	0	987,000	52.00
53.00	05300	ANESTHESIOLOGY	100,675		100,675	0	100,675	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,343,711		6,343,711	0	6,343,711	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,011,577		3,011,577	0	3,011,577	59.00
60.00	06000	LABORATORY	6,449,053		6,449,053	0	6,449,053	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	566,927		566,927	0	566,927	62.00
65.00	06500	RESPIRATORY THERAPY	1,650,806	0	1,650,806	0	1,650,806	65.00
66.00	06600	PHYSICAL THERAPY	1,244,006	0	1,244,006	0	1,244,006	66.00
67.00	06700	OCCUPATIONAL THERAPY	758,316	0	758,316	0	758,316	67.00
68.00	06800	SPEECH PATHOLOGY	182,227	0	182,227	0	182,227	68.00
69.00	06900	ELECTROCARDIOLOGY	489,665		489,665	0	489,665	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,990,292		1,990,292	0	1,990,292	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,187,202		5,187,202	0	5,187,202	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,484,122		7,484,122	0	7,484,122	73.00
74.00	07400	RENAL DIALYSIS	578,756		578,756	0	578,756	74.00
76.00	03950	MISC ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	0		0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,065,079		1,065,079	0	1,065,079	76.02
76.03	03952	WOUND CARE	1,704,235		1,704,235	0	1,704,235	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	243,638		243,638	0	243,638	90.00
91.00	09100	EMERGENCY	6,567,939		6,567,939	0	6,567,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,035,847		2,035,847		2,035,847	92.00
200.00		Subtotal (see instructions)	82,980,635	0	82,980,635	0	82,980,635	200.00
201.00		Less Observation Beds	2,035,847		2,035,847		2,035,847	201.00
202.00		Total (see instructions)	80,944,788	0	80,944,788	0	80,944,788	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet C Part I Date/Time Prepared: 10/31/2018 1:09 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,155,552		42,155,552			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	2,072,063		2,072,063			31.01
33.00	03300	BURN INTENSIVE CARE UNIT	14,033,621		14,033,621			33.00
40.00	04000	SUBPROVIDER - IPF	18,728,652		18,728,652			40.00
43.00	04300	NURSERY	709,186		709,186			43.00
44.00	04400	SKILLED NURSING FACILITY	4,099,060		4,099,060			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,687,885	24,448,975	43,136,860	0.111032	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,257,816	1,615,887	2,873,703	0.400728	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,177,189	451,252	1,628,441	0.606101	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,956,904	3,007,225	5,964,129	0.016880	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,572,501	54,897,267	73,469,768	0.086345	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,693,456	13,152,286	22,845,742	0.131822	0.000000	59.00
60.00	06000	LABORATORY	25,878,876	32,925,234	58,804,110	0.109670	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,658,124	254,486	2,912,610	0.194646	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	11,613,230	2,152,988	13,766,218	0.119917	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,326,926	733,456	4,060,382	0.306377	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,957,385	102,125	4,059,510	0.186800	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	485,249	65,876	551,125	0.330645	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,365,993	2,212,882	3,578,875	0.136821	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,608,240	24,831,558	41,439,798	0.048029	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,367,700	5,282,025	10,649,725	0.487074	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,508,074	17,370,770	72,878,844	0.102693	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,434,239	70,365	1,504,604	0.384657	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	306,164	2,764,308	3,070,472	0.346878	0.000000	76.02
76.03	03952	WOUND CARE	1,506,504	3,517,546	5,024,050	0.339215	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,187	126,576	133,763	1.821415	0.000000	90.00
91.00	09100	EMERGENCY	8,065,255	35,844,527	43,909,782	0.149578	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,052,850	6,091,904	7,144,754	0.284943	0.000000	92.00
200.00		Subtotal (see instructions)	273,285,881	231,919,518	505,205,399			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	273,285,881	231,919,518	505,205,399			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet C Part I Date/Time Prepared: 10/31/2018 1:09 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		31.01
33.00	03300	BURN INTENSIVE CARE UNIT		33.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.111032	50.00
51.00	05100	RECOVERY ROOM	0.400728	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.606101	52.00
53.00	05300	ANESTHESIOLOGY	0.016880	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086345	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.131822	59.00
60.00	06000	LABORATORY	0.109670	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.194646	62.00
65.00	06500	RESPIRATORY THERAPY	0.119917	65.00
66.00	06600	PHYSICAL THERAPY	0.306377	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186800	67.00
68.00	06800	SPEECH PATHOLOGY	0.330645	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136821	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.048029	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.487074	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.102693	73.00
74.00	07400	RENAL DIALYSIS	0.384657	74.00
76.00	03950	MISC ANCILLARY	0.000000	76.00
76.01	03951	SLEEP LAB	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.346878	76.02
76.03	03952	WOUND CARE	0.339215	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	1.821415	90.00
91.00	09100	EMERGENCY	0.149578	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284943	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet C Part I Date/Time Prepared: 10/31/2018 1:09 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,713,028		15,713,028	0	15,713,028	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	2,612,261		2,612,261	0	2,612,261	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	3,168,934		3,168,934	0	3,168,934	33.00
40.00	04000	SUBPROVIDER - IPF	3,540,810		3,540,810	0	3,540,810	40.00
43.00	04300	NURSERY	444,279		444,279	0	444,279	43.00
44.00	04400	SKILLED NURSING FACILITY	2,919,126		2,919,126	0	2,919,126	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,789,551		4,789,551	0	4,789,551	50.00
51.00	05100	RECOVERY ROOM	1,151,573		1,151,573	0	1,151,573	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	987,000		987,000	0	987,000	52.00
53.00	05300	ANESTHESIOLOGY	100,675		100,675	0	100,675	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,343,711		6,343,711	0	6,343,711	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,011,577		3,011,577	0	3,011,577	59.00
60.00	06000	LABORATORY	6,449,053		6,449,053	0	6,449,053	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	566,927		566,927	0	566,927	62.00
65.00	06500	RESPIRATORY THERAPY	1,650,806	0	1,650,806	0	1,650,806	65.00
66.00	06600	PHYSICAL THERAPY	1,244,006	0	1,244,006	0	1,244,006	66.00
67.00	06700	OCCUPATIONAL THERAPY	758,316	0	758,316	0	758,316	67.00
68.00	06800	SPEECH PATHOLOGY	182,227	0	182,227	0	182,227	68.00
69.00	06900	ELECTROCARDIOLOGY	489,665		489,665	0	489,665	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,990,292		1,990,292	0	1,990,292	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,187,202		5,187,202	0	5,187,202	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,484,122		7,484,122	0	7,484,122	73.00
74.00	07400	RENAL DIALYSIS	578,756		578,756	0	578,756	74.00
76.00	03950	MISC ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	0		0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,065,079		1,065,079	0	1,065,079	76.02
76.03	03952	WOUND CARE	1,704,235		1,704,235	0	1,704,235	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	243,638		243,638	0	243,638	90.00
91.00	09100	EMERGENCY	6,567,939		6,567,939	0	6,567,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,035,847		2,035,847		2,035,847	92.00
200.00		Subtotal (see instructions)	82,980,635	0	82,980,635	0	82,980,635	200.00
201.00		Less Observation Beds	2,035,847		2,035,847		2,035,847	201.00
202.00		Total (see instructions)	80,944,788	0	80,944,788	0	80,944,788	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet C Part I | Date/Time Prepared: 10/31/2018 1:09 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,155,552		42,155,552			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	2,072,063		2,072,063			31.01
33.00	03300	BURN INTENSIVE CARE UNIT	14,033,621		14,033,621			33.00
40.00	04000	SUBPROVIDER - IPF	18,728,652		18,728,652			40.00
43.00	04300	NURSERY	709,186		709,186			43.00
44.00	04400	SKILLED NURSING FACILITY	4,099,060		4,099,060			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,687,885	24,448,975	43,136,860	0.111032	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,257,816	1,615,887	2,873,703	0.400728	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,177,189	451,252	1,628,441	0.606101	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,956,904	3,007,225	5,964,129	0.016880	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,572,501	54,897,267	73,469,768	0.086345	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,693,456	13,152,286	22,845,742	0.131822	0.000000	59.00
60.00	06000	LABORATORY	25,878,876	32,925,234	58,804,110	0.109670	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,658,124	254,486	2,912,610	0.194646	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	11,613,230	2,152,988	13,766,218	0.119917	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,326,926	733,456	4,060,382	0.306377	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,957,385	102,125	4,059,510	0.186800	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	485,249	65,876	551,125	0.330645	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,365,993	2,212,882	3,578,875	0.136821	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,608,240	24,831,558	41,439,798	0.048029	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,367,700	5,282,025	10,649,725	0.487074	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,508,074	17,370,770	72,878,844	0.102693	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,434,239	70,365	1,504,604	0.384657	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	306,164	2,764,308	3,070,472	0.346878	0.000000	76.02
76.03	03952	WOUND CARE	1,506,504	3,517,546	5,024,050	0.339215	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,187	126,576	133,763	1.821415	0.000000	90.00
91.00	09100	EMERGENCY	8,065,255	35,844,527	43,909,782	0.149578	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,052,850	6,091,904	7,144,754	0.284943	0.000000	92.00
200.00		Subtotal (see instructions)	273,285,881	231,919,518	505,205,399			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	273,285,881	231,919,518	505,205,399			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet C Part I Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		31.01
33.00	03300	BURN INTENSIVE CARE UNIT		33.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.111032	50.00
51.00	05100	RECOVERY ROOM	0.400728	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.606101	52.00
53.00	05300	ANESTHESIOLOGY	0.016880	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086345	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.131822	59.00
60.00	06000	LABORATORY	0.109670	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.194646	62.00
65.00	06500	RESPIRATORY THERAPY	0.119917	65.00
66.00	06600	PHYSICAL THERAPY	0.306377	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186800	67.00
68.00	06800	SPEECH PATHOLOGY	0.330645	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136821	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.048029	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.487074	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.102693	73.00
74.00	07400	RENAL DIALYSIS	0.384657	74.00
76.00	03950	MISC ANCILLARY	0.000000	76.00
76.01	03951	SLEEP LAB	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.346878	76.02
76.03	03952	WOUND CARE	0.339215	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	1.821415	90.00
91.00	09100	EMERGENCY	0.149578	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284943	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet C Part II | Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,789,551	771,907	4,017,644	0	0	50.00
51.00	05100	RECOVERY ROOM	1,151,573	256,601	894,972	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	987,000	229,762	757,238	0	0	52.00
53.00	05300	ANESTHESIOLOGY	100,675	9,382	91,293	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,343,711	759,199	5,584,512	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,011,577	142,737	2,868,840	0	0	59.00
60.00	06000	LABORATORY	6,449,053	658,179	5,790,874	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	566,927	44,773	522,154	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,650,806	244,354	1,406,452	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,244,006	288,787	955,219	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	758,316	115,582	642,734	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	182,227	42,503	139,724	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	489,665	47,020	442,645	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,990,292	94,836	1,895,456	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,187,202	140,827	5,046,375	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,484,122	231,648	7,252,474	0	0	73.00
74.00	07400	RENAL DIALYSIS	578,756	78,858	499,898	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,065,079	130,411	934,668	0	0	76.02
76.03	03952	WOUND CARE	1,704,235	337,288	1,366,947	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	243,638	83,260	160,378	0	0	90.00
91.00	09100	EMERGENCY	6,567,939	658,416	5,909,523	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,035,847	248,913	1,786,934	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	54,582,197	5,615,243	48,966,954	0	0	200.00
201.00		Less Observation Beds	2,035,847	248,913	1,786,934	0	0	201.00
202.00		Total (line 200 minus line 201)	52,546,350	5,366,330	47,180,020	0	0	202.00

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

Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet C Part II Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,789,551	43,136,860	0.111032		50.00
51.00	05100	RECOVERY ROOM	1,151,573	2,873,703	0.400728		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	987,000	1,628,441	0.606101		52.00
53.00	05300	ANESTHESIOLOGY	100,675	5,964,129	0.016880		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,343,711	73,469,768	0.086345		54.00
54.01	03630	ULTRA SOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	3,011,577	22,845,742	0.131822		59.00
60.00	06000	LABORATORY	6,449,053	58,804,110	0.109670		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	566,927	2,912,610	0.194646		62.00
65.00	06500	RESPIRATORY THERAPY	1,650,806	13,766,218	0.119917		65.00
66.00	06600	PHYSICAL THERAPY	1,244,006	4,060,382	0.306377		66.00
67.00	06700	OCCUPATIONAL THERAPY	758,316	4,059,510	0.186800		67.00
68.00	06800	SPEECH PATHOLOGY	182,227	551,125	0.330645		68.00
69.00	06900	ELECTROCARDIOLOGY	489,665	3,578,875	0.136821		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,990,292	41,439,798	0.048029		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,187,202	10,649,725	0.487074		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,484,122	72,878,844	0.102693		73.00
74.00	07400	RENAL DIALYSIS	578,756	1,504,604	0.384657		74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000		76.00
76.01	03951	SLEEP LAB	0	0	0.000000		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,065,079	3,070,472	0.346878		76.02
76.03	03952	WOUND CARE	1,704,235	5,024,050	0.339215		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	243,638	133,763	1.821415		90.00
91.00	09100	EMERGENCY	6,567,939	43,909,782	0.149578		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,035,847	7,144,754	0.284943		92.00
200.00		Subtotal (sum of lines 50 thru 199)	54,582,197	423,407,265			200.00
201.00		Less Observation Beds	2,035,847	0			201.00
202.00		Total (line 200 minus line 201)	52,546,350	423,407,265			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part I Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,921,148	0	1,921,148	19,419	98.93	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	587,215		587,215	569	1,032.01	31.01
33.00	BURN INTENSIVE CARE UNIT	355,739		355,739	2,065	172.27	33.00
40.00	SUBPROVIDER - IPF	349,413	0	349,413	5,484	63.71	40.00
43.00	NURSERY	6,575		6,575	586	11.22	43.00
44.00	SKILLED NURSING FACILITY	465,057		465,057	5,091	91.35	44.00
200.00	Total (lines 30 through 199)	3,685,147		3,685,147	33,214		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	3,946	390,378	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	0	0	31.01
33.00	BURN INTENSIVE CARE UNIT	405	69,769	33.00
40.00	SUBPROVIDER - IPF	3,409	217,187	40.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	2,215	202,340	44.00
200.00	Total (lines 30 through 199)	9,975	879,674	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part II Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	771,907	43,136,860	0.017894	5,488,283	98,207	50.00
51.00	05100	RECOVERY ROOM	256,601	2,873,703	0.089293	384,443	34,328	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	229,762	1,628,441	0.141093	14,378	2,029	52.00
53.00	05300	ANESTHESIOLOGY	9,382	5,964,129	0.001573	690,152	1,086	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	759,199	73,469,768	0.010333	5,973,330	61,722	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	142,737	22,845,742	0.006248	3,069,328	19,177	59.00
60.00	06000	LABORATORY	658,179	58,804,110	0.011193	5,608,051	62,771	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	44,773	2,912,610	0.015372	836,086	12,852	62.00
65.00	06500	RESPIRATORY THERAPY	244,354	13,766,218	0.017750	2,726,682	48,399	65.00
66.00	06600	PHYSICAL THERAPY	288,787	4,060,382	0.071123	286,480	20,375	66.00
67.00	06700	OCCUPATIONAL THERAPY	115,582	4,059,510	0.028472	250,532	7,133	67.00
68.00	06800	SPEECH PATHOLOGY	42,503	551,125	0.077120	54,835	4,229	68.00
69.00	06900	ELECTROCARDIOLOGY	47,020	3,578,875	0.013138	291,262	3,827	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	94,836	41,439,798	0.002289	6,495,021	14,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	140,827	10,649,725	0.013224	1,559,384	20,621	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	231,648	72,878,844	0.003179	12,263,266	38,985	73.00
74.00	07400	RENAL DIALYSIS	78,858	1,504,604	0.052411	952,018	49,896	74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	130,411	3,070,472	0.042473	14,504	616	76.02
76.03	03952	WOUND CARE	337,288	5,024,050	0.067135	375,534	25,211	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	83,260	133,763	0.622444	0	0	90.00
91.00	09100	EMERGENCY	658,416	43,909,782	0.014995	1,625,114	24,369	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	248,913	7,144,754	0.034839	385,507	13,431	92.00
200.00		Total (lines 50 through 199)	5,615,243	423,407,265		49,344,190	564,131	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part III Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	19,419	0.00	3,946	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0	569	0.00	0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT		0	2,065	0.00	405	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	5,484	0.00	3,409	40.00
43.00	04300	NURSERY		0	586	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	5,091	0.00	2,215	44.00
200.00		Total (lines 30 through 199)		0	33,214		9,975	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV | Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV | Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	43,136,860	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,873,703	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,628,441	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,964,129	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	73,469,768	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	22,845,742	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	58,804,110	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,912,610	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,766,218	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,060,382	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,059,510	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	551,125	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,578,875	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	41,439,798	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,649,725	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	72,878,844	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,504,604	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	3,070,472	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	5,024,050	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	133,763	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	43,909,782	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,144,754	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	423,407,265		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	5,488,283	0	5,063,583	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	384,443	0	1,148,634	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	14,378	0	10,462	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	690,152	0	648,714	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	5,973,330	0	8,493,744	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	3,069,328	0	2,348,321	0	59.00
60.00	06000	LABORATORY	0.000000	5,608,051	0	2,297,341	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	836,086	0	46,075	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,726,682	0	479,608	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	286,480	0	24,504	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	250,532	0	21,408	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	54,835	0	4,332	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	291,262	0	430,820	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	6,495,021	0	7,194,609	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,559,384	0	1,465,310	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	12,263,266	0	3,008,348	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	952,018	0	70,364	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	14,504	0	1,119,308	0	76.02
76.03	03952	WOUND CARE	0.000000	375,534	0	976,736	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	11,348	0	90.00
91.00	09100	EMERGENCY	0.000000	1,625,114	0	3,579,272	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	385,507	0	1,323,864	0	92.00
200.00		Total (lines 50 through 199)		49,344,190	0	39,766,705	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part V Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.111032	5,063,583	0	0	562,220	50.00
51.00	05100	RECOVERY ROOM	0.400728	1,148,634	0	0	460,290	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.606101	10,462	0	0	6,341	52.00
53.00	05300	ANESTHESIOLOGY	0.016880	648,714	0	0	10,950	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086345	8,493,744	0	0	733,392	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.131822	2,348,321	0	0	309,560	59.00
60.00	06000	LABORATORY	0.109670	2,297,341	0	0	251,949	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.194646	46,075	0	0	8,968	62.00
65.00	06500	RESPIRATORY THERAPY	0.119917	479,608	0	0	57,513	65.00
66.00	06600	PHYSICAL THERAPY	0.306377	24,504	0	0	7,507	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186800	21,408	0	0	3,999	67.00
68.00	06800	SPEECH PATHOLOGY	0.330645	4,332	0	0	1,432	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136821	430,820	0	0	58,945	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.048029	7,194,609	0	0	345,550	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.487074	1,465,310	0	0	713,714	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.102693	3,008,348	0	29,694	308,936	73.00
74.00	07400	RENAL DIALYSIS	0.384657	70,364	0	0	27,066	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.346878	1,119,308	0	0	388,263	76.02
76.03	03952	WOUND CARE	0.339215	976,736	0	0	331,324	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.821415	11,348	0	160	20,669	90.00
91.00	09100	EMERGENCY	0.149578	3,579,272	0	0	535,380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284943	1,323,864	0	0	377,226	92.00
200.00		Subtotal (see instructions)		39,766,705	0	29,854	5,521,194	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		39,766,705	0	29,854	5,521,194	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part V Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,049		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03952	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	291		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	3,340		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	3,340		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part II Date/Time Prepared: 10/31/2018 1:09 pm

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	771,907	43,136,860	0.017894	0	0	50.00
51.00	05100	RECOVERY ROOM	256,601	2,873,703	0.089293	227,870	20,347	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	229,762	1,628,441	0.141093	0	0	52.00
53.00	05300	ANESTHESIOLOGY	9,382	5,964,129	0.001573	60,869	96	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	759,199	73,469,768	0.010333	461,158	4,765	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	142,737	22,845,742	0.006248	0	0	59.00
60.00	06000	LABORATORY	658,179	58,804,110	0.011193	1,261,190	14,116	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	44,773	2,912,610	0.015372	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	244,354	13,766,218	0.017750	168,424	2,990	65.00
66.00	06600	PHYSICAL THERAPY	288,787	4,060,382	0.071123	251,948	17,919	66.00
67.00	06700	OCCUPATIONAL THERAPY	115,582	4,059,510	0.028472	309,650	8,816	67.00
68.00	06800	SPEECH PATHOLOGY	42,503	551,125	0.077120	35,242	2,718	68.00
69.00	06900	ELECTROCARDIOLOGY	47,020	3,578,875	0.013138	68,325	898	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	94,836	41,439,798	0.002289	27,140	62	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	140,827	10,649,725	0.013224	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	231,648	72,878,844	0.003179	2,296,802	7,302	73.00
74.00	07400	RENAL DIALYSIS	78,858	1,504,604	0.052411	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	130,411	3,070,472	0.042473	221,279	9,398	76.02
76.03	03952	WOUND CARE	337,288	5,024,050	0.067135	752	50	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	83,260	133,763	0.622444	0	0	90.00
91.00	09100	EMERGENCY	658,416	43,909,782	0.014995	389,122	5,835	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,144,754	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	5,366,330	423,407,265		5,779,771	95,312	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV Date/Time Prepared: 10/31/2018 1:09 pm

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV | Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	43,136,860	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,873,703	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,628,441	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,964,129	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	73,469,768	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	22,845,742	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	58,804,110	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,912,610	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,766,218	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,060,382	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,059,510	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	551,125	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,578,875	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	41,439,798	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,649,725	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	72,878,844	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,504,604	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	3,070,472	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	5,024,050	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	133,763	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	43,909,782	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,144,754	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	423,407,265		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV Date/Time Prepared: 10/31/2018 1:09 pm

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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	227,870	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	60,869	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	461,158	0	2,580	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,261,190	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	168,424	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	251,948	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	309,650	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	35,242	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	68,325	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	27,140	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,296,802	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	221,279	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	752	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	389,122	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		5,779,771	0	2,580	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part V | Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.111032	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.400728	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.606101	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016880	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086345	2,580	0	0	223	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.131822	0	0	0	0	59.00
60.00	06000	LABORATORY	0.109670	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.194646	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.119917	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.306377	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186800	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.330645	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136821	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.048029	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.487074	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.102693	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.384657	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.346878	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.339215	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.821415	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.149578	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284943	0	0	0	0	92.00
200.00		Subtotal (see instructions)		2,580	0	0	223	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		2,580	0	0	223	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part V | Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03952	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-5356
Period: From 06/01/2017 To 05/31/2018
Worksheet D Part IV
Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	43,136,860	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,873,703	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,628,441	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,964,129	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	73,469,768	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	22,845,742	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	58,804,110	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,912,610	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,766,218	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,060,382	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,059,510	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	551,125	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,578,875	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	41,439,798	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,649,725	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	72,878,844	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,504,604	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	3,070,472	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	5,024,050	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	133,763	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	43,909,782	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,144,754	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	423,407,265		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV | Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Skilled Nursing Facility | 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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	122,732	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	338,313	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	33,467	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	438,818	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,243,802	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,216,958	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	14,193	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	5,776	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	174,751	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,062,832	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	143,917	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		7,795,559	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part I Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,921,148	0	1,921,148	19,419	98.93	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	587,215		587,215	569	1,032.01	31.01
33.00	BURN INTENSIVE CARE UNIT	355,739		355,739	2,065	172.27	33.00
40.00	SUBPROVIDER - IPF	349,413	0	349,413	5,484	63.71	40.00
43.00	NURSERY	6,575		6,575	586	11.22	43.00
44.00	SKILLED NURSING FACILITY	465,057		465,057	5,091	91.35	44.00
200.00	Total (lines 30 through 199)	3,685,147		3,685,147	33,214		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	991	98,040		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
31.01	NEONATAL INTENSIVE CARE UNIT	19	19,608		31.01
33.00	BURN INTENSIVE CARE UNIT	141	24,290		33.00
40.00	SUBPROVIDER - IPF	389	24,783		40.00
43.00	NURSERY	51	572		43.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
200.00	Total (lines 30 through 199)	1,591	167,293		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part II Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	771,907	43,136,860	0.017894	1,025,856	18,357	50.00
51.00	05100	RECOVERY ROOM	256,601	2,873,703	0.089293	74,820	6,681	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	229,762	1,628,441	0.141093	336,581	47,489	52.00
53.00	05300	ANESTHESIOLOGY	9,382	5,964,129	0.001573	188,728	297	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	759,199	73,469,768	0.010333	747,401	7,723	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	142,737	22,845,742	0.006248	298,652	1,866	59.00
60.00	06000	LABORATORY	658,179	58,804,110	0.011193	1,212,952	13,577	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	44,773	2,912,610	0.015372	134,738	2,071	62.00
65.00	06500	RESPIRATORY THERAPY	244,354	13,766,218	0.017750	685,436	12,166	65.00
66.00	06600	PHYSICAL THERAPY	288,787	4,060,382	0.071123	48,245	3,431	66.00
67.00	06700	OCCUPATIONAL THERAPY	115,582	4,059,510	0.028472	34,328	977	67.00
68.00	06800	SPEECH PATHOLOGY	42,503	551,125	0.077120	31,622	2,439	68.00
69.00	06900	ELECTROCARDIOLOGY	47,020	3,578,875	0.013138	38,546	506	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	94,836	41,439,798	0.002289	662,314	1,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	140,827	10,649,725	0.013224	174,474	2,307	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	231,648	72,878,844	0.003179	2,210,262	7,026	73.00
74.00	07400	RENAL DIALYSIS	78,858	1,504,604	0.052411	142,083	7,447	74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	130,411	3,070,472	0.042473	0	0	76.02
76.03	03952	WOUND CARE	337,288	5,024,050	0.067135	90,004	6,042	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	83,260	133,763	0.622444	160	100	90.00
91.00	09100	EMERGENCY	658,416	43,909,782	0.014995	300,093	4,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	248,913	7,144,754	0.034839	36,090	1,257	92.00
200.00		Total (lines 50 through 199)	5,615,243	423,407,265		8,473,385	147,775	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part III Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	19,419	0.00	991	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0	569	0.00	19	31.01
33.00	03300	BURN INTENSIVE CARE UNIT		0	2,065	0.00	141	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	5,484	0.00	389	40.00
43.00	04300	NURSERY		0	586	0.00	51	43.00
44.00	04400	SKILLED NURSING FACILITY		0	5,091	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	33,214		1,591	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV | Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV | Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	43,136,860	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,873,703	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,628,441	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,964,129	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	73,469,768	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	22,845,742	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	58,804,110	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,912,610	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,766,218	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,060,382	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,059,510	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	551,125	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,578,875	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	41,439,798	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,649,725	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	72,878,844	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,504,604	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	3,070,472	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	5,024,050	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	133,763	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	43,909,782	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,144,754	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	423,407,265		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV | Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,025,856	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	74,820	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	336,581	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	188,728	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	747,401	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	298,652	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,212,952	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	134,738	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	685,436	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	48,245	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	34,328	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	31,622	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	38,546	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	662,314	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	174,474	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,210,262	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	142,083	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	90,004	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	160	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	300,093	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	36,090	0	0	0	92.00
200.00		Total (lines 50 through 199)		8,473,385	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part V Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.111032	0	0	1,269,371	0	50.00
51.00	05100	RECOVERY ROOM	0.400728	0	0	197,649	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.606101	0	0	68,634	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016880	0	0	246,960	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086345	0	0	1,434,785	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.131822	0	0	42,216	0	59.00
60.00	06000	LABORATORY	0.109670	0	0	975,946	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.194646	0	0	5,376	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.119917	0	0	42,041	0	65.00
66.00	06600	PHYSICAL THERAPY	0.306377	0	0	7,582	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186800	0	0	5,284	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.330645	0	0	6,374	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136821	0	0	57,848	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.048029	0	0	137,893	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.487074	0	0	83,006	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.102693	0	0	515,104	0	73.00
74.00	07400	RENAL DIALYSIS	0.384657	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.346878	0	0	32,268	0	76.02
76.03	03952	WOUND CARE	0.339215	0	0	95,409	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.821415	0	0	2,600	0	90.00
91.00	09100	EMERGENCY	0.149578	0	0	1,345,194	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284943	0	0	211,874	0	92.00
200.00		Subtotal (see instructions)		0	0	6,783,414	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	6,783,414	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part V Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	140,941		50.00
51.00	05100	RECOVERY ROOM	0	79,203		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	41,599		52.00
53.00	05300	ANESTHESIOLOGY	0	4,169		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	123,887		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,565		59.00
60.00	06000	LABORATORY	0	107,032		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,046		62.00
65.00	06500	RESPIRATORY THERAPY	0	5,041		65.00
66.00	06600	PHYSICAL THERAPY	0	2,323		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	987		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,108		68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,915		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,623		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,430		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	52,898		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	11,193		76.02
76.03	03952	WOUND CARE	0	32,364		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	4,736		90.00
91.00	09100	EMERGENCY	0	201,211		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	60,372		92.00
200.00		Subtotal (see instructions)	0	931,643		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	931,643		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part II Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	771,907	43,136,860	0.017894	0	0	50.00
51.00	05100	RECOVERY ROOM	256,601	2,873,703	0.089293	7,765	693	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	229,762	1,628,441	0.141093	0	0	52.00
53.00	05300	ANESTHESIOLOGY	9,382	5,964,129	0.001573	2,287	4	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	759,199	73,469,768	0.010333	39,597	409	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	142,737	22,845,742	0.006248	0	0	59.00
60.00	06000	LABORATORY	658,179	58,804,110	0.011193	116,050	1,299	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	44,773	2,912,610	0.015372	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	244,354	13,766,218	0.017750	23,560	418	65.00
66.00	06600	PHYSICAL THERAPY	288,787	4,060,382	0.071123	21,722	1,545	66.00
67.00	06700	OCCUPATIONAL THERAPY	115,582	4,059,510	0.028472	31,823	906	67.00
68.00	06800	SPEECH PATHOLOGY	42,503	551,125	0.077120	2,215	171	68.00
69.00	06900	ELECTROCARDIOLOGY	47,020	3,578,875	0.013138	4,664	61	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	94,836	41,439,798	0.002289	2,565	6	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	140,827	10,649,725	0.013224	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	231,648	72,878,844	0.003179	322,628	1,026	73.00
74.00	07400	RENAL DIALYSIS	78,858	1,504,604	0.052411	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	130,411	3,070,472	0.042473	8,323	354	76.02
76.03	03952	WOUND CARE	337,288	5,024,050	0.067135	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	83,260	133,763	0.622444	0	0	90.00
91.00	09100	EMERGENCY	658,416	43,909,782	0.014995	38,156	572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,144,754	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	5,366,330	423,407,265		621,355	7,464	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-S047
Period: From 06/01/2017 To 05/31/2018
Worksheet D Part IV Date/Time Prepared: 10/31/2018 1:09 pm
Title XIX
Subprovider - IPF
PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV | Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	43,136,860	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,873,703	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,628,441	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,964,129	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	73,469,768	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	22,845,742	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	58,804,110	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,912,610	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,766,218	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,060,382	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,059,510	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	551,125	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,578,875	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	41,439,798	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,649,725	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	72,878,844	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,504,604	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	3,070,472	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	5,024,050	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	133,763	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	43,909,782	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,144,754	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	423,407,265		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | 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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	7,765	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,287	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	39,597	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	116,050	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	23,560	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	21,722	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	31,823	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,215	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,664	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,565	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	322,628	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	8,323	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	38,156	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		621,355	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-1 | Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,419	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,419	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)	16,903	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)	3,946	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)	15,713,028	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)	15,713,028	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)	15,713,028	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)	809.16	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,192,945	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)	3,192,945	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-1 | Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	2,612,261	569	4,590.97	0	0	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	3,168,934	2,065	1,534.59	405	621,509	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)	6,183,856	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	9,998,310	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)	460,147	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	564,131	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,024,278	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,974,032	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,516	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	809.16	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,035,847	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-1 | Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,921,148	15,713,028	0.122265	2,035,847	248,913	90.00
91.00	Nursing School cost	0	15,713,028	0.000000	2,035,847	0	91.00
92.00	Allied health cost	0	15,713,028	0.000000	2,035,847	0	92.00
93.00	All other Medical Education	0	15,713,028	0.000000	2,035,847	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047 Component CCN: 15-S047	Period: From 06/01/2017 To 05/31/2018	Worksheet D-1 Date/Time Prepared: 10/31/2018 1:09 pm
	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)	5,484	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,484	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)	5,484	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)	3,409	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)	3,540,810	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)	3,540,810	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)	3,540,810	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)	645.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,201,055	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)	2,201,055	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-1 | Date/Time Prepared: 10/31/2018 1:09 pm

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
43.01	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	819,092	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,020,147	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)	217,187	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	95,312	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	312,499	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,707,648	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: 15-0047
Component CCN: 15-S047

Period:
From 06/01/2017
To 05/31/2018

Worksheet D-1
Date/Time Prepared:
10/31/2018 1:09 pm

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	349,413	3,540,810	0.098682	0	0	90.00
91.00	Nursing School cost	0	3,540,810	0.000000	0	0	91.00
92.00	Allied health cost	0	3,540,810	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,540,810	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047 Component CCN: 15-5356	Period: From 06/01/2017 To 05/31/2018	Worksheet D-1 Date/Time Prepared: 10/31/2018 1:09 pm
	Title XVIII	Skilled Nursing Facility	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)	5,091	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,091	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)	5,091	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)	2,215	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)	2,919,126	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)	2,919,126	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)	2,919,126	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-1 | Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Skilled Nursing Facility | 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
43.01	NEONATAL INTENSIVE CARE UNIT						43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,919,126	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	573.39	71.00
72.00	Program routine service cost (line 9 x line 71)	1,270,059	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,270,059	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,270,059	83.00
84.00	Program inpatient ancillary services (see instructions)	1,195,155	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,465,214	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: 15-0047 Component CCN: 15-5356	Period: From 06/01/2017 To 05/31/2018	Worksheet D-1 Date/Time Prepared: 10/31/2018 1:09 pm
	Title XVIII	Skilled Nursing Facility	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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-1 | Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,419	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,419	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)	16,903	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)	991	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)	586	15.00
16.00	Nursery days (title V or XIX only)	51	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)	15,713,028	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)	15,713,028	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)	15,713,028	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)	809.16	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	801,878	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)	801,878	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-1 | Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	444,279	586	758.16	51	38,666	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	2,612,261	569	4,590.97	19	87,228	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	3,168,934	2,065	1,534.59	141	216,377	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)	1,217,760	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,361,909	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)	142,510	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	147,775	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	290,285	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,071,624	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,516	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	809.16	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,035,847	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-1 | Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,921,148	15,713,028	0.122265	2,035,847	248,913	90.00
91.00	Nursing School cost	0	15,713,028	0.000000	2,035,847	0	91.00
92.00	Allied health cost	0	15,713,028	0.000000	2,035,847	0	92.00
93.00	All other Medical Education	0	15,713,028	0.000000	2,035,847	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047 Component CCN: 15-S047	Period: From 06/01/2017 To 05/31/2018	Worksheet D-1 Date/Time Prepared: 10/31/2018 1:09 pm
	Title XIX	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)	5,484	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,484	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)	5,484	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)	389	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)	586	15.00
16.00	Nursery days (title V or XIX only)	51	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)	3,540,810	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)	3,540,810	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)	3,540,810	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)	645.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	251,162	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)	251,162	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-1 | Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	77,941	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	329,103	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)	24,783	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	7,464	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	32,247	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	296,856	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: 15-0047 Component CCN: 15-S047	Period: From 06/01/2017 To 05/31/2018	Worksheet D-1 Date/Time Prepared: 10/31/2018 1:09 pm
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	349,413	3,540,810	0.098682	0	0	90.00
91.00	Nursing School cost	0	3,540,810	0.000000	0	0	91.00
92.00	Allied health cost	0	3,540,810	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,540,810	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-3 | Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		10,478,386		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0		31.01
33.00	03300	BURN INTENSIVE CARE UNIT		2,473,034		33.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111032	5,488,283	609,375	50.00
51.00	05100	RECOVERY ROOM	0.400728	384,443	154,057	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.606101	14,378	8,715	52.00
53.00	05300	ANESTHESIOLOGY	0.016880	690,152	11,650	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086345	5,973,330	515,767	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.131822	3,069,328	404,605	59.00
60.00	06000	LABORATORY	0.109670	5,608,051	615,035	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.194646	836,086	162,741	62.00
65.00	06500	RESPIRATORY THERAPY	0.119917	2,726,682	326,976	65.00
66.00	06600	PHYSICAL THERAPY	0.306377	286,480	87,771	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186800	250,532	46,799	67.00
68.00	06800	SPEECH PATHOLOGY	0.330645	54,835	18,131	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136821	291,262	39,851	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.048029	6,495,021	311,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.487074	1,559,384	759,535	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.102693	12,263,266	1,259,352	73.00
74.00	07400	RENAL DIALYSIS	0.384657	952,018	366,200	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.346878	14,504	5,031	76.02
76.03	03952	WOUND CARE	0.339215	375,534	127,387	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.821415	0	0	90.00
91.00	09100	EMERGENCY	0.149578	1,625,114	243,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284943	385,507	109,848	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		49,344,190	6,183,856	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)		49,344,190		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-3 | Date/Time Prepared: 10/31/2018 1:09 pm

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
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0		31.01
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
40.00	04000	SUBPROVIDER - IPF		11,572,432		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111032	0	0	50.00
51.00	05100	RECOVERY ROOM	0.400728	227,870	91,314	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.606101	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016880	60,869	1,027	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086345	461,158	39,819	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.131822	0	0	59.00
60.00	06000	LABORATORY	0.109670	1,261,190	138,315	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.194646	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.119917	168,424	20,197	65.00
66.00	06600	PHYSICAL THERAPY	0.306377	251,948	77,191	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186800	309,650	57,843	67.00
68.00	06800	SPEECH PATHOLOGY	0.330645	35,242	11,653	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136821	68,325	9,348	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.048029	27,140	1,304	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.487074	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.102693	2,296,802	235,865	73.00
74.00	07400	RENAL DIALYSIS	0.384657	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.346878	221,279	76,757	76.02
76.03	03952	WOUND CARE	0.339215	752	255	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.821415	0	0	90.00
91.00	09100	EMERGENCY	0.149578	389,122	58,204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284943	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,779,771	819,092	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)		5,779,771		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-3 | Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0		31.01
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111032	0	0	50.00
51.00	05100	RECOVERY ROOM	0.400728	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.606101	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016880	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086345	122,732	10,597	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.131822	0	0	59.00
60.00	06000	LABORATORY	0.109670	338,313	37,103	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.194646	33,467	6,514	62.00
65.00	06500	RESPIRATORY THERAPY	0.119917	438,818	52,622	65.00
66.00	06600	PHYSICAL THERAPY	0.306377	1,243,802	381,072	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186800	1,216,958	227,328	67.00
68.00	06800	SPEECH PATHOLOGY	0.330645	14,193	4,693	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136821	5,776	790	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.048029	174,751	8,393	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.487074	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.102693	4,062,832	417,224	73.00
74.00	07400	RENAL DIALYSIS	0.384657	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.346878	0	0	76.02
76.03	03952	WOUND CARE	0.339215	143,917	48,819	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.821415	0	0	90.00
91.00	09100	EMERGENCY	0.149578	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284943	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,795,559	1,195,155	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)		7,795,559		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-3 | Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,941,446		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		70,421		31.01
33.00	03300	BURN INTENSIVE CARE UNIT		971,173		33.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		60,457		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111032	1,025,856	113,903	50.00
51.00	05100	RECOVERY ROOM	0.400728	74,820	29,982	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.606101	336,581	204,002	52.00
53.00	05300	ANESTHESIOLOGY	0.016880	188,728	3,186	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086345	747,401	64,534	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.131822	298,652	39,369	59.00
60.00	06000	LABORATORY	0.109670	1,212,952	133,024	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.194646	134,738	26,226	62.00
65.00	06500	RESPIRATORY THERAPY	0.119917	685,436	82,195	65.00
66.00	06600	PHYSICAL THERAPY	0.306377	48,245	14,781	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186800	34,328	6,412	67.00
68.00	06800	SPEECH PATHOLOGY	0.330645	31,622	10,456	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136821	38,546	5,274	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.048029	662,314	31,810	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.487074	174,474	84,982	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.102693	2,210,262	226,978	73.00
74.00	07400	RENAL DIALYSIS	0.384657	142,083	54,653	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.346878	0	0	76.02
76.03	03952	WOUND CARE	0.339215	90,004	30,531	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.821415	160	291	90.00
91.00	09100	EMERGENCY	0.149578	300,093	44,887	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284943	36,090	10,284	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,473,385	1,217,760	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)		8,473,385		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-3 | Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0		31.01
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
40.00	04000	SUBPROVIDER - IPF		1,327,267		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111032	0	0	50.00
51.00	05100	RECOVERY ROOM	0.400728	7,765	3,112	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.606101	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016880	2,287	39	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086345	39,597	3,419	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.131822	0	0	59.00
60.00	06000	LABORATORY	0.109670	116,050	12,727	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.194646	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.119917	23,560	2,825	65.00
66.00	06600	PHYSICAL THERAPY	0.306377	21,722	6,655	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186800	31,823	5,945	67.00
68.00	06800	SPEECH PATHOLOGY	0.330645	2,215	732	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136821	4,664	638	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.048029	2,565	123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.487074	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.102693	322,628	33,132	73.00
74.00	07400	RENAL DIALYSIS	0.384657	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.346878	8,323	2,887	76.02
76.03	03952	WOUND CARE	0.339215	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.821415	0	0	90.00
91.00	09100	EMERGENCY	0.149578	38,156	5,707	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284943	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		621,355	77,941	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)		621,355		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Period: From 06/01/2017 To 05/31/2018	Worksheet E Part A Date/Time Prepared: 10/31/2018 1:09 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,570,925	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,513,793	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)	382,014	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	4,289,788	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	102.09	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)	8.95	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	1.89	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).	0.05	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)	7.11	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	1.02	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)	1.02	12.00
13.00	Total allowable FTE count for the prior year.	5.29	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.	5.13	14.00
15.00	Sum of lines 12 through 14 divided by 3.	3.81	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	3.81	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.037320	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.051427	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.037320	21.00
22.00	IME payment adjustment (see instructions)	142,991	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	86,581	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).	4.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	-6.09	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)	142,991	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	86,581	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	13.76	30.00
31.00	Percentage of Medicaid patient days (see instructions)	43.95	31.00
32.00	Sum of lines 30 and 31	57.71	32.00
33.00	Allowable disproportionate share percentage (see instructions)	36.83	33.00
34.00	Disproportionate share adjustment (see instructions)	652,326	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet E Part A Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,326,754	1,606,994	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	443,464	1,069,861	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,513,325		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	9,775,374		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		9,861,955	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		731,404	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).		124,150	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		5,459	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		10,722,968	59.00
60.00	Primary payer payments		3,775	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		10,719,193	61.00
62.00	Deductibles billed to program beneficiaries		688,952	62.00
63.00	Coinsurance billed to program beneficiaries		44,655	63.00
64.00	Allowable bad debts (see instructions)		270,294	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		175,691	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		149,191	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		10,161,277	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-15,657	70.93
70.94	HRR adjustment amount (see instructions)		-13,603	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Period: From 06/01/2017 To 05/31/2018	Worksheet E Part A Date/Time Prepared: 10/31/2018 1:09 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		36,456	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,095,561	71.00
71.01	Sequestration adjustment (see instructions)		201,911	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		9,409,680	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)		483,970	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,709,088	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Period: From 06/01/2017 To 05/31/2018	Worksheet E Part B Date/Time Prepared: 10/31/2018 1:09 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,340	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,521,194	2.00
3.00	OPPS payments	4,236,614	3.00
4.00	Outlier payment (see instructions)	35,924	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)	3,340	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	29,854	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)	29,854	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	29,854	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	26,514	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)	3,340	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)	4,272,538	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	771,325	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)	3,504,553	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	44,991	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)	3,549,544	30.00
31.00	Primary payer payments	792	31.00
32.00	Subtotal (line 30 minus line 31)	3,548,752	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)	365,894	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	237,831	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	292,766	36.00
37.00	Subtotal (see instructions)	3,786,583	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)	3,786,583	40.00
40.01	Sequestration adjustment (see instructions)	75,732	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,707,013	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	3,838	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: 15-0047 Component CCN: 15-S047	Period: From 06/01/2017 To 05/31/2018	Worksheet E Part B Date/Time Prepared: 10/31/2018 1:09 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	223	2.00
3.00	OPPS payments	161	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)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	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)	0	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)	161	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	32	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)	129	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)	129	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	129	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)	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)	129	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)	129	40.00
40.01	Sequestration adjustment (see instructions)	3	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	126	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	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: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,367,580		3,619,113	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	02/14/2018	42,100	02/14/2018	87,900	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		42,100		87,900	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)		9,409,680		3,707,013	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		483,970		3,838	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		9,893,650		3,710,851	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: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 10/31/2018 1:09 pm

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		2,669,784		126	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,669,784		126	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		9		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,669,793		126	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: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2017 To 05/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 10/31/2018 1:09 pm

Title XVIII | Skilled Nursing Facility | 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		785,548		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		785,548		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		101		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		785,649		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0047	Period: From 06/01/2017 To 05/31/2018	Worksheet E-1 Part II Date/Time Prepared: 10/31/2018 1:09 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047 Component CCN: 15-S047	Period: From 06/01/2017 To 05/31/2018	Worksheet E-3 Part II Date/Time Prepared: 10/31/2018 1:09 pm
	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)	2,977,691	1.00
2.00	Net IPF PPS Outlier Payments	4,245	2.00
3.00	Net IPF PPS ECT Payments	11,160	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 instuctions)	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 instuctions)	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)	15.024658	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) 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)	2,993,096	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)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,993,096	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,993,096	18.00
19.00	Deductibles	169,648	19.00
20.00	Subtotal (line 18 minus line 19)	2,823,448	20.00
21.00	Coinsurance	99,169	21.00
22.00	Subtotal (line 20 minus line 21)	2,724,279	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,724,279	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)	0	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)	2,724,279	31.00
31.01	Sequestration adjustment (see instructions)	54,486	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	2,669,784	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)	9	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	4,245	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: 15-0047 Component CCN: 15-5356	Period: From 06/01/2017 To 05/31/2018	Worksheet E-3 Part VI Date/Time Prepared: 10/31/2018 1:09 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	958,371	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	958,371	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	156,791	7.00
8.00	Allowable bad debts (see instructions)	158	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	103	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	801,683	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	801,683	15.00
15.01	Sequestration adjustment (see instructions)	16,034	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	785,548	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	101	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet E-3 Part VII Date/Time Prepared: 10/31/2018 1:09 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		931,643	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	931,643	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	931,643	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	8,473,385	6,783,414	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)	8,473,385	6,783,414	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)	8,473,385	6,783,414	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	8,473,385	5,851,771	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	931,643	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	931,643	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	931,643	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	931,643	36.00
37.00	ELIMINATE SETTLEMENT	0	-931,643	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047 Component CCN: 15-S047	Period: From 06/01/2017 To 05/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 10/31/2018 1:09 pm
	Title XIX	Subprovider - IPF	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		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	621,355	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)	621,355	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)	621,355	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	621,355	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		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	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	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	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		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: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet E-4 | Date/Time Prepared: 10/31/2018 1:09 pm

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.			7.63	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))			-0.80	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			6.83	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			1.02	6.00
7.00	Enter the lesser of line 5 or line 6			1.02	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.	1.02	0.00	1.02	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.	1.02	0.00	1.02	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	1.02	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	5.29	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	5.13	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	3.81	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	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	3.81	0.00		17.00
18.00	Per resident amount	100,092.68	94,778.98		18.00
19.00	Approved amount for resident costs	381,353	0	381,353	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)			5.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			99,539.45	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)			381,353	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	7,760	3,943		26.00
27.00	Total Inpatient Days (see instructions)	25,130	25,130		27.00
28.00	Ratio of inpatient days to total inpatient days	0.308794	0.156904		28.00
29.00	Program direct GME amount	117,760	59,836		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		8,455		30.00
31.00	Net Program direct GME amount			169,141	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet E-4 | Date/Time Prepared: 10/31/2018 1:09 pm

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)	1,504,604	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)	15,246,887	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)	3,775	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	15,243,112	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	5,524,757	42.00
43.00	Primary payer payments (see instructions)	792	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	5,523,965	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	20,767,077	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.734004	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.265996	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	169,141	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	124,150	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	44,991	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet G | Date/Time Prepared: 10/31/2018 1:09 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-480,630	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	34,731,769	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,551,152	0	0	0	6.00
7.00	Inventory	3,333,704	0	0	0	7.00
8.00	Prepaid expenses	1,283,801	0	0	0	8.00
9.00	Other current assets	986,296	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	25,303,788	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,010,000	0	0	0	12.00
13.00	Land improvements	412,126	0	0	0	13.00
14.00	Accumulated depreciation	-316,600	0	0	0	14.00
15.00	Buildings	28,350,171	0	0	0	15.00
16.00	Accumulated depreciation	-18,078,777	0	0	0	16.00
17.00	Leasehold improvements	22,204,810	0	0	0	17.00
18.00	Accumulated depreciation	-7,441,035	0	0	0	18.00
19.00	Fixed equipment	1,542,344	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	22,967,715	0	0	0	23.00
24.00	Accumulated depreciation	-17,258,781	0	0	0	24.00
25.00	Minor equipment depreciable	8,426,816	0	0	0	25.00
26.00	Accumulated depreciation	-6,893,875	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)	34,924,914	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	8,215,772	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,215,772	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	68,444,474	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,597,130	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,898,187	0	0	0	38.00
39.00	Payroll taxes payable	297,051	0	0	0	39.00
40.00	Notes and loans payable (short term)	12,963	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	27,266,449	0	0	0	43.00
44.00	Other current liabilities	1,825,218	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	34,896,998	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	34,896,998	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	33,547,476				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)	33,547,476	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	68,444,474	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet G-1 | Date/Time Prepared: 10/31/2018 1:09 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		42,314,499		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8,767,023				2.00
3.00	Total (sum of line 1 and line 2)		33,547,476		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		33,547,476		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)		33,547,476		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 10/31/2018 1:09 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	42,864,738		42,864,738	1.00
2.00	SUBPROVIDER - IPF	18,728,652		18,728,652	2.00
3.00	SUBPROVIDER - IRF				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	4,099,060		4,099,060	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)	65,692,450		65,692,450	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	2,072,063		2,072,063	11.01
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	14,033,621		14,033,621	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)	16,105,684		16,105,684	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	81,798,134		81,798,134	17.00
18.00	Ancillary services	182,362,455	189,856,511	372,218,966	18.00
19.00	Outpatient services	9,125,292	42,063,007	51,188,299	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	273,285,881	231,919,518	505,205,399	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		91,920,798		29.00
30.00	ROUNDING	7			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)		7		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)		91,920,805		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2017 To 05/31/2018 | Worksheet G-3 | Date/Time Prepared: 10/31/2018 1:09 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	505,205,399	1.00
2.00	Less contractual allowances and discounts on patients' accounts	422,161,457	2.00
3.00	Net patient revenues (line 1 minus line 2)	83,043,942	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	91,920,805	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,876,863	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	109,840	24.00
25.00	Total other income (sum of lines 6-24)	109,840	25.00
26.00	Total (line 5 plus line 25)	-8,767,023	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)	-8,767,023	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0047	Period: From 06/01/2017 To 05/31/2018	Worksheet L Parts I-III Date/Time Prepared: 10/31/2018 1:09 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	568,974	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	80,441	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)	54.14	3.00
4.00	Number of interns & residents (see instructions)	3.81	4.00
5.00	Indirect medical education percentage (see instructions)	2.01	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)	11,436	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	13.76	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	43.95	8.00
9.00	Sum of lines 7 and 8	57.71	9.00
10.00	Allowable disproportionate share percentage (see instructions)	12.40	10.00
11.00	Disproportionate share adjustment (see instructions)	70,553	11.00
12.00	Total prospective capital payments (see instructions)	731,404	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