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: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet S Parts I-III Date/Time Prepared: 1/30/2019 11:15 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/30/2019 Time: 11:15 am
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 TERRE HAUTE REGIONAL HOSPITAL (15-0046) for the cost reporting period beginning 09/01/2017 and ending 08/31/2018 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.

[X] 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) DUSTIN FOSNESS
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
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	118,568	145,195	0	-2,865,990	1.00
2.00	Subprovider - IPF	0	10,131	-377		94,110	2.00
3.00	Subprovider - IRF	0	6,694	-136		-7,724	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	135,393	144,682	0	-2,779,604	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: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 1/30/2019 11:15 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 3901 HOSPITAL LANE	PO Box:			1.00
2.00	City: TERRE HAUTE	State: IN	Zip Code: 47802	County: VIGO	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	TERRE HAUTE REGIONAL HOSPITAL	150046	45460	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	TERRE HAUTE PSYCHIATRIC UNIT	15S046	45460	4	09/01/1991	N	P	O	4.00
5.00	Subprovider - IRF	TERRE HAUTE REHAB UNIT	15T046	45460	5	09/01/2006	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	09/01/2017	08/31/2018	20.00
21.00	Type of Control (see instructions)	4		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	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.	550	230	87	101	3,572	82	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 1/30/2019 11:15 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	59	44	0	0	252		25.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part I Date/Time Prepared: 1/30/2019 11:15 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part I Date/Time Prepared: 1/30/2019 11:15 am

		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.	Y			75.00

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		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

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

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

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

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

		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.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	361,215	0	939,587	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.	Y	5.00	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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part I Date/Time Prepared: 1/30/2019 11:15 am

		1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	44H070	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: HOSPITAL CORP. OF AMERICA	Contractor's Name: PALMETTO	Contractor's Number: 10001	141.00
142.00	Street: ONE PARK PLAZA	PO Box:		142.00
143.00	City: NASHVILLE	State: TN	Zip Code: 37203	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)	N	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)	10/01/2017	12/31/2017	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part I Date/Time Prepared: 1/30/2019 11:15 am

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 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: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 1/30/2019 11:15 am

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

		Y/N	Date	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.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/17/2018	Y	12/17/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part II Date/Time Prepared: 1/30/2019 11:15 am

Line	Question	Description	Y/N	Y/N	Line
		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

Line	Question	Y/N	Date	Y/N	Date	Line
		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

Line	Question	1.00	Line
	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	Y	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.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

Line	Question	Y/N	Date	Line
		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	12/31/2017	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

Line	Question	1.00	2.00	Line
	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.	JAMES	WELLS	41.00
42.00	Enter the employer/company name of the cost report preparer.	HCA		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-344-6359	JAMES.WELLS2@HCAHEALTHCARE.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part II Date/Time Prepared: 1/30/2019 11:15 am

		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.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 1/30/2019 11:15 am

	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	146	53,290	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)		146	53,290	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	18	6,570	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		164	59,860	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	41.00	12	4,380		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		195				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 1/30/2019 11:15 am

	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)	8,853	968	16,395			1.00
2.00	HMO and other (see instructions)	1,837	3,572				2.00
3.00	HMO IPF Subprovider	247	0				3.00
4.00	HMO IRF Subprovider	85	252				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)	8,853	968	16,395			7.00
8.00	INTENSIVE CARE UNIT	1,593	0	3,295			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY		0	979			13.00
14.00	Total (see instructions)	10,446	968	20,669	0.00	540.05	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,424	2,875	6,598	0.00	35.03	16.00
17.00	SUBPROVIDER - IRF	1,264	103	2,094	0.00	11.76	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	113			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	586.84	27.00
28.00	Observation Bed Days		645	1,914			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	82	107			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			56			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: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 1/30/2019 11:15 am

	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	2,555	253	5,228	1.00
2.00	HMO and other (see instructions)			379	1,136		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				17		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,555	253	5,228	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	227	542	1,203	16.00
17.00	SUBPROVIDER - IRF	0.00	0	95	7	154	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 1/30/2019 11:15 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	36,104,758	0	36,104,758	1,220,634.00	29.58	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,582,877	23,831	3,606,708	129,385.00	27.88	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,929,662	0	1,929,662	30,435.00	63.40	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		345,233	0	345,233	1,924.25	179.41	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		6,533,042	0	6,533,042	176,134.00	37.09	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)		9,355,518	0	9,355,518			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,038,297	0	1,038,297			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)		1,326,729	0	1,326,729			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part II | Date/Time Prepared: 1/30/2019 11:15 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	113,455	0	113,455	4,388.00	25.86	26.00
27.00	Administrative & General	5.00	5,043,251	-248,444	4,794,807	139,587.00	34.35	27.00
28.00	Administrative & General under contract (see inst.)		104,980	0	104,980	360.00	291.61	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	677,421	0	677,421	24,144.00	28.06	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	886,265	0	886,265	63,648.00	13.92	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	172,404	-47,169	125,235	8,903.00	14.07	34.00
35.00	Dietary under contract (see instructions)		1,006,054	0	1,006,054	42,857.00	23.47	35.00
36.00	Cafeteria	11.00	0	47,169	47,169	3,353.00	14.07	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	489,868	248,444	738,312	14,504.00	50.90	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	17,075	0	17,075	554.00	30.82	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: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 1/30/2019 11:15 am

		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)		37,215,792	0	37,215,792	1,263,851.00	29.45	1.00
2.00	Excluded area salaries (see instructions)		3,582,877	23,831	3,606,708	129,385.00	27.88	2.00
3.00	Subtotal salaries (line 1 minus line 2)		33,632,915	-23,831	33,609,084	1,134,466.00	29.63	3.00
4.00	Subtotal other wages & related costs (see inst.)		8,807,937	0	8,807,937	208,493.25	42.25	4.00
5.00	Subtotal wage-related costs (see inst.)		10,682,247	0	10,682,247	0.00	31.78	5.00
6.00	Total (sum of lines 3 thru 5)		53,123,099	-23,831	53,099,268	1,342,959.25	39.54	6.00
7.00	Total overhead cost (see instructions)		8,510,773	0	8,510,773	302,298.00	28.15	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 1/30/2019 11:15 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,246,285	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	84,441	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)	0	8.02
8.03	Health Insurance (Purchased)	5,559,168	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	24,035	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	35,442	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	407,685	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	121,387	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	2,218,039	17.00
18.00	Medicare Taxes - Employers Portion Only	516,998	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	102,125	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	78,210	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,393,815	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: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part V | Date/Time Prepared: 1/30/2019 11:15 am

	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	1,928,097	10,393,815	1.00
2.00	Hospital	1,929,662	9,355,518	2.00
3.00	Subprovider - IPF	0	532,868	3.00
4.00	Subprovider - IRF	-1,565	244,115	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	261,314	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-10 | Date/Time Prepared: 1/30/2019 11:15 am

		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)	0.147539	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	22,516,724	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	169,430,070	6.00
7.00	Medicaid cost (line 1 times line 6)	24,997,543	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,480,819	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,480,819	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)	27,445,262	300,096	27,745,358	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,049,247	239,883	4,289,130	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	4,049,247	239,883	4,289,130	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?	Y	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	70,634	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	6,764,792	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	446,275	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	686,577	27.01
28.00	Non-Medicare bad debt expense (see instructions)	6,078,215	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,137,076	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	5,426,206	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,907,025	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A | Date/Time Prepared: 1/30/2019 11:15 am

		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		3,093,031	3,093,031	291,743	3,384,774	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,772,612	2,772,612	754,673	3,527,285	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	113,455	7,800,172	7,913,627	103,230	8,016,857	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,043,251	14,699,482	19,742,733	-454,777	19,287,956	5.00
7.00	00700	OPERATION OF PLANT	677,421	3,320,143	3,997,564	-2,958	3,994,606	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	756,602	756,602	0	756,602	8.00
9.00	00900	HOUSEKEEPING	886,265	403,070	1,289,335	-7,831	1,281,504	9.00
10.00	01000	DIETARY	172,404	1,925,999	2,098,403	-578,938	1,519,465	10.00
11.00	01100	CAFETERIA	0	0	0	572,290	572,290	11.00
13.00	01300	NURSING ADMINISTRATION	489,868	302,873	792,741	228,858	1,021,599	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,075	1,014,408	1,031,483	-273	1,031,210	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,444,774	3,747,917	9,192,691	-73,016	9,119,675	30.00
31.00	03100	INTENSIVE CARE UNIT	1,941,539	604,888	2,546,427	-54,242	2,492,185	31.00
40.00	04000	SUBPROVIDER - IPF	1,851,011	988,368	2,839,379	-15,706	2,823,673	40.00
41.00	04100	SUBPROVIDER - IRF	847,975	105,495	953,470	-1,001	952,469	41.00
43.00	04300	NURSERY	286,019	233,557	519,576	-270	519,306	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,920,392	5,564,486	9,484,878	-45,253	9,439,625	50.00
51.00	05100	RECOVERY ROOM	484,139	96,055	580,194	-706	579,488	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	778,465	347,195	1,125,660	-7,488	1,118,172	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	940,218	892,271	1,832,489	-205,961	1,626,528	54.00
54.01	03630	ULTRA SOUND	160,765	28,927	189,692	0	189,692	54.01
54.02	03440	MAMMOGRAPHY	114,401	89,127	203,528	-771	202,757	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	589,454	444,387	1,033,841	-44,252	989,589	55.00
56.00	05600	RADIOISOTOPE	160,543	621,665	782,208	-77	782,131	56.00
57.00	05700	CT SCAN	533,257	212,040	745,297	-1,751	743,546	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	246,816	106,111	352,927	0	352,927	58.00
59.00	05900	CARDIAC CATHETERIZATION	511,239	33,122	544,361	0	544,361	59.00
60.00	06000	LABORATORY	1,234,073	1,807,906	3,041,979	-99,157	2,942,822	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	662,576	662,576	0	662,576	62.00
65.00	06500	RESPIRATORY THERAPY	916,094	437,287	1,353,381	-98,397	1,254,984	65.00
66.00	06600	PHYSICAL THERAPY	880,950	165,048	1,045,998	-123	1,045,875	66.00
69.00	06900	ELECTROCARDIOLOGY	463,642	375,744	839,386	-3,269	836,117	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	47,673	18,359	66,032	-967	65,065	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	369,480	6,762,036	7,131,516	-202,567	6,928,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,033,723	6,033,723	287,974	6,321,697	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,493,192	10,979,425	12,472,617	-6,602	12,466,015	73.00
74.00	07400	RENAL DIALYSIS	68	536,827	536,895	0	536,895	74.00
76.00	03950	LITHOTRIPSY	0	231,984	231,984	0	231,984	76.00
76.01	03330	ENDOSCOPY	767,364	548,378	1,315,742	-139,277	1,176,465	76.01
76.02	03040	PRISION CLINIC	139,992	18,665	158,657	-989	157,668	76.02
76.03	03050	WOUND CARE	65,555	566,450	632,005	-1,286	630,719	76.03
76.04	03060	OPIC	457,297	111,339	568,636	-1,291	567,345	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,174,741	9,606,844	11,781,585	-213,622	11,567,963	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)	35,220,867	89,066,594	124,287,461	-24,050	124,263,411	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	49,597	49,597	0	49,597	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	639,849	141,536	781,385	-1,560	779,825	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	0	194.01
194.02	07952	SITTERS	244,042	19,435	263,477	0	263,477	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	25,610	25,610	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	36,104,758	89,277,162	125,381,920	0	125,381,920	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A | Date/Time Prepared: 1/30/2019 11:15 am

		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	174,045	3,558,819	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-977	3,526,308	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	284,763	8,301,620	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,106,611	26,394,567	5.00
7.00	00700	OPERATION OF PLANT	81,859	4,076,465	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	756,602	8.00
9.00	00900	HOUSEKEEPING	19,966	1,301,470	9.00
10.00	01000	DIETARY	-1,801	1,517,664	10.00
11.00	01100	CAFETERIA	-283,161	289,129	11.00
13.00	01300	NURSING ADMINISTRATION	-17,748	1,003,851	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	41,561	1,072,771	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-1,717,290	7,402,385	30.00
31.00	03100	INTENSIVE CARE UNIT	-7,691	2,484,494	31.00
40.00	04000	SUBPROVIDER - IPF	-679,142	2,144,531	40.00
41.00	04100	SUBPROVIDER - IRF	-21	952,448	41.00
43.00	04300	NURSERY	-142,431	376,875	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-4,516,887	4,922,738	50.00
51.00	05100	RECOVERY ROOM	-67	579,421	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-17,635	1,100,537	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,282	1,678,810	54.00
54.01	03630	ULTRA SOUND	0	189,692	54.01
54.02	03440	MAMMOGRAPHY	0	202,757	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,377	988,212	55.00
56.00	05600	RADIOISOTOPE	0	782,131	56.00
57.00	05700	CT SCAN	0	743,546	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	352,927	58.00
59.00	05900	CARDIAC CATHETERIZATION	-3,614	540,747	59.00
60.00	06000	LABORATORY	-429	2,942,393	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	662,576	62.00
65.00	06500	RESPIRATORY THERAPY	-95,250	1,159,734	65.00
66.00	06600	PHYSICAL THERAPY	-42,441	1,003,434	66.00
69.00	06900	ELECTROCARDIOLOGY	-9,639	826,478	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	65,065	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-284	6,928,665	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,321,697	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-176	12,465,839	73.00
74.00	07400	RENAL DIALYSIS	0	536,895	74.00
76.00	03950	LITHOTRIPSY	0	231,984	76.00
76.01	03330	ENDOSCOPY	-64,123	1,112,342	76.01
76.02	03040	PRISION CLINIC	0	157,668	76.02
76.03	03050	WOUND CARE	-11,596	619,123	76.03
76.04	03060	OPIC	-25,809	541,536	76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	-8,480,218	3,087,745	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,358,720	115,904,691	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	49,597	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	-240,557	539,268	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	194.01
194.02	07952	SITTERS	-48	263,429	194.02
194.03	07953	UNLICENSED STAFF	0	25,610	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,599,325	116,782,595	200.00

RECLASSIFICATIONS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-6 | Date/Time Prepared: 1/30/2019 11:15 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LEASES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	276,091	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	741,259	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
	0		0	1,017,350	
	B - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	29,066	1.00
	0		0	29,066	
	C - EXECUTIVE COMP.				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	104,742	1.00
2.00	NURSING ADMINISTRATION	13.00	248,444	22,236	2.00
	0		248,444	126,978	
	D - CAFETERIA				
1.00	CAFETERIA	11.00	47,169	525,121	1.00
	0		47,169	525,121	
	E - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	234,195	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
	0		0	234,195	
	F - DRUG				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,325	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	4,325	
	G - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	428,593	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		0	428,593	

RECLASSIFICATIONS

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	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	H - ER BEDHOLD				
1.00	ADULTS & PEDIATRICS	30.00	74,384	35,265	1.00
2.00	INTENSIVE CARE UNIT	31.00	3,713	1,760	2.00
	0		78,097	37,025	
	I - LOST CHARGES				
1.00		0.00	0	0	1.00
	0		0	0	
	J - EQUIPMENT PROPERTY TAX				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,414	1.00
	0		0	13,414	
	L - UNLICENSED STAFF				
1.00	UNLICENSED STAFF	194.03	23,831	1,779	1.00
2.00		0.00	0	0	2.00
	TOTALS		23,831	1,779	
500.00	Grand Total: Increases		397,541	2,417,846	500.00

RECLASSIFICATIONS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-6 | Date/Time Prepared: 1/30/2019 11:15 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LEASES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,512	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	50,289	10		2.00
3.00	OPERATION OF PLANT	7.00	0	2,958	0		3.00
4.00	HOUSEKEEPING	9.00	0	7,831	0		4.00
5.00	DIETARY	10.00	0	6,648	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	41,822	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	273	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	165,736	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	58,605	0		9.00
10.00	SUBPROVIDER - IPF	40.00	0	15,706	0		10.00
11.00	SUBPROVIDER - IRF	41.00	0	1,001	0		11.00
12.00	OPERATING ROOM	50.00	0	26,249	0		12.00
13.00	RECOVERY ROOM	51.00	0	706	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	7,462	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	201,776	0		15.00
16.00	MAMMOGRAPHY	54.02	0	771	0		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	4,548	0		17.00
18.00	RADIOISOTOPE	56.00	0	77	0		18.00
19.00	LABORATORY	60.00	0	98,781	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	40,285	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	123	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	2,280	0		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	967	0		23.00
24.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	51,202	0		24.00
25.00	DRUGS CHARGED TO PATIENTS	73.00	0	963	0		25.00
26.00	ENDOSCOPY	76.01	0	133,457	0		26.00
27.00	PRISION CLINIC	76.02	0	989	0		27.00
28.00	WOUND CARE	76.03	0	1,093	0		28.00
29.00	OPIC	76.04	0	1,291	0		29.00
30.00	EMERGENCY	91.00	0	90,389	0		30.00
31.00	OCCUPATIONAL MEDICINE	194.00	0	1,560	0		31.00
	0		0	1,017,350			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	29,066	12		1.00
	0		0	29,066			
	C - EXECUTIVE COMP.						
1.00	ADMINISTRATIVE & GENERAL	5.00	248,444	126,978	0		1.00
2.00		0.00	0	0	0		2.00
	0		248,444	126,978			
	D - CAFETERIA						
1.00	DIETARY	10.00	47,169	525,121	0		1.00
	0		47,169	525,121			
	E - MEDICAL SUPPLIES						
1.00	INTENSIVE CARE UNIT	31.00	0	1,110	0		1.00
2.00	NURSERY	43.00	0	270	0		2.00
3.00	OPERATING ROOM	50.00	0	16,866	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,147	0		4.00
5.00	CT SCAN	57.00	0	1,751	0		5.00
6.00	LABORATORY	60.00	0	376	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	58,112	0		7.00
8.00	ELECTROCARDIOLOGY	69.00	0	989	0		8.00
9.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	140,619	0		9.00
10.00	ENDOSCOPY	76.01	0	1,651	0		10.00
11.00	WOUND CARE	76.03	0	193	0		11.00
12.00	EMERGENCY	91.00	0	8,111	0		12.00
	0		0	234,195			
	F - DRUG						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	38	0		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	118	0		2.00
3.00	ENDOSCOPY	76.01	0	4,169	0		3.00
	0		0	4,325			
	G - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	2,138	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	26	0		2.00
3.00	RADIOLOGY-THERAPEUTIC	55.00	0	39,704	0		3.00
4.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	385,442	0		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,283	0		5.00
	0		0	428,593			

RECLASSIFICATIONS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-6 | Date/Time Prepared: 1/30/2019 11:15 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	H - ER BEDHOLD					
1.00	EMERGENCY	91.00	78,097	37,025	0	1.00
2.00		0.00	0	0	0	2.00
	0		78,097	37,025		
	I - LOST CHARGES					
1.00		0.00	0	0	0	1.00
	0		0	0		
	J - EQUIPMENT PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13,414	13	1.00
	0		0	13,414		
	L - UNLICENSED STAFF					
1.00	DRUGS CHARGED TO PATIENTS	73.00	8,076	605	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	15,755	1,174	0	2.00
	TOTALS		23,831	1,779		
500.00	Grand Total: Decreases		397,541	2,417,846		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-7 Part I Date/Time Prepared: 1/30/2019 11:15 am

		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	1,262,718	0	0	0	0	1.00
2.00	Land Improvements	3,158,371	0	0	0	0	2.00
3.00	Buildings and Fixtures	38,638,215	0	0	0	0	3.00
4.00	Building Improvements	8,056,094	65,121	0	65,121	0	4.00
5.00	Fixed Equipment	27,079,070	22,118	0	22,118	115,729	5.00
6.00	Movable Equipment	46,356,854	2,602,261	0	2,602,261	527,152	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	124,551,322	2,689,500	0	2,689,500	642,881	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	124,551,322	2,689,500	0	2,689,500	642,881	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,262,718	0	1.00
2.00	Land Improvements	3,158,371	0	2.00
3.00	Buildings and Fixtures	38,638,215	0	3.00
4.00	Building Improvements	8,121,215	0	4.00
5.00	Fixed Equipment	26,985,459	0	5.00
6.00	Movable Equipment	48,431,963	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	126,597,941	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	126,597,941	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-7 Part II Date/Time Prepared: 1/30/2019 11:15 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,365,943	0	0	0	727,088	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,584,697	179,660	8,255	0	0	2.00
3.00	Total (sum of lines 1-2)	4,950,640	179,660	8,255	0	727,088	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	3,093,031	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,772,612	2.00
3.00	Total (sum of lines 1-2)	0	5,865,643	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 1/30/2019 11:15 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	78,165,979	0	78,165,979	0.617435	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	48,431,962	0	48,431,962	0.382565	0	2.00
3.00	Total (sum of lines 1-2)	126,597,941	0	126,597,941	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,539,988	276,091	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,583,720	920,919	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,123,708	1,197,010	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	29,066	713,674	0	3,558,819	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,255	0	13,414	0	3,526,308	2.00
3.00	Total (sum of lines 1-2)	8,255	29,066	727,088	0	7,085,127	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-8 | Date/Time Prepared: 1/30/2019 11:15 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-11,971,633			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	8,236,167			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-8 | Date/Time Prepared: 1/30/2019 11:15 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	X-RAY COPY	B	-825	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00
33.01	CAFETERIA	B	-270,756	CAFETERIA	11.00	0	33.01
33.02	VENDING	B	-12,405	CAFETERIA	11.00	0	33.02
33.03	MEDICAL RECORDS	B	-1,320	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	ED OTHER	B	-1,930	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	INCOME - COMP REHAB	B	-99	SUBPROVIDER - IRF	41.00	0	33.05
33.06	COMP REHAB	B	-1,081	ELECTROCARDIOLOGY	69.00	0	33.06
33.07	OTHER REVENUE	B	-1,168	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	PATHOLOGY SLIDES	B	-420	LABORATORY	60.00	0	33.08
33.09	INTEREST INCOME	B	-88,209	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	HOSPICE	B	-88,527	ADULTS & PEDIATRICS	30.00	0	33.10
33.11	UNCLAIMED PROPERTY	B	-3,567	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	WORKER'S COMP. PAID CLAIMS	A	-71,202	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	WORKER'S COMP INSURANCE	A	21,075	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	PATIENT TELEPHONES	A	-9,691	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	PATIENT TELEPHONES	A	-46,539	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	PATIENT TV'S	A	-35,577	OPERATION OF PLANT	7.00	0	33.16
33.17	PATIENT TV'S	A	-1,801	DIETARY	10.00	0	33.17
33.18	PATIENT TV'S	A	-3,512	RADIOLOGY-DIAGNOSTIC	54.00	0	33.18
33.19	CONSULTING 900-317	A	-65,753	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	ADMIN. TRAVEL 900-750	A	-4,303	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	ADMIN. MEALS 900-764	A	-3,809	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	ADMIN. PARTIES & BANQUETS 900-760	A	-800	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	MISC. XXX870	A	-1,864	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	MISC. XXX870	A	-1,946	OCCUPATIONAL MEDICINE	194.00	0	33.24
33.25	MISC. XXX870	A	-660	OPERATING ROOM	50.00	0	33.25
33.26	NONPATIENT GIFTS	A	-18,334	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	NONPATIENT GIFTS	A	-627	HOUSEKEEPING	9.00	0	33.27
33.28	NONPATIENT GIFTS	A	-35	OPERATING ROOM	50.00	0	33.28
33.29	NONPATIENT GIFTS	A	-3,508	EMERGENCY	91.00	0	33.29
33.30	PATIENT GIFTS	A	-101	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	ALCOHOL	A	-5,611	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	ALCOHOL	A	-63	ADULTS & PEDIATRICS	30.00	0	33.32
33.33	ALCOHOL	A	-7	INTENSIVE CARE UNIT	31.00	0	33.33
33.34	ALCOHOL	A	-10	SUBPROVIDER - IRF	41.00	0	33.34
33.35	ALCOHOL	A	-22	NURSERY	43.00	0	33.35
33.36	ALCOHOL	A	-10	OPERATING ROOM	50.00	0	33.36
33.37	ALCOHOL	A	-9	LABORATORY	60.00	0	33.37
33.38	ALCOHOL	A	-187	EMERGENCY	91.00	0	33.38
33.39	ED ENT. NON EMPLOYEE	A	-2,715	EMERGENCY	91.00	0	33.39
33.40	COUNTRY CLUB DUES	A	-2,283	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	NONALLOWABLES 900805	A	-7,106	ADMINISTRATIVE & GENERAL	5.00	0	33.41
33.42	PHYSICIAN RECRUITMENT 900827	A	-57,002	ADMINISTRATIVE & GENERAL	5.00	0	33.42
33.43	CONTRIBUTIONS	A	-28,064	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	OCC MEDCONTRIBUTION NONALLOWABLES 83	A	-1,000	OCCUPATIONAL MEDICINE	194.00	0	33.44
33.45	MED STAFF NONALLOWABLES 843	A	-109,670	ADMINISTRATIVE & GENERAL	5.00	0	33.45
33.46	PUBLIC RELATIONS DEPT. 920	A	-84,318	ADMINISTRATIVE & GENERAL	5.00	0	33.46
33.47	REHAB ADMPHYS RECR/CY DEPT 950	A	-9,646	ADMINISTRATIVE & GENERAL	5.00	0	33.47
33.48	SALES DEPT. 965	A	-4,832	ADMINISTRATIVE & GENERAL	5.00	0	33.48
33.49	LEGAL FEES	A	-21,777	ADMINISTRATIVE & GENERAL	5.00	0	33.49
33.50	CLINICAL RESEARCH	A	-1,377	RADIOLOGY-THERAPEUTIC	55.00	0	33.50
33.51	CLINICAL RESEARCH	A	-176	DRUGS CHARGED TO PATIENTS	73.00	0	33.51
33.52	CLINICAL RESEARCH	A	-214	OPIC	76.04	0	33.52
33.53	CLINICAL RESEARCH	A	-341	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.53
33.54	DEPRECIATION BUILDING	A	112	CAP REL COSTS-BLDG & FIXT	1.00	9	33.54
33.55	DEPRECIATION MME	A	-977	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.55
33.56	CRNA	A	-3,302,662	OPERATING ROOM	50.00	0	33.56
33.57	NURSE PRACTITIONER	A	-237,611	OCCUPATIONAL MEDICINE	194.00	0	33.57
33.58	NURSE PRACTITIONER	A	-587	ADMINISTRATIVE & GENERAL	5.00	0	33.58

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-8 | Date/Time Prepared: 1/30/2019 11:15 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.59	LOBBYING DUES	A	-12,856	ADMINISTRATIVE & GENERAL	5.00	0	33.59
33.60	MOB ACCOUNTING	A	-1,074	ADMINISTRATIVE & GENERAL	5.00	0	33.60
33.61	MOB ACCOUNTING	A	-302	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.61
33.62	USEFUL LIFE ADJUSTMENT	A	-44,512	CAP REL COSTS-BLDG & FIXT	1.00	9	33.62
33.63	PHYSICIAN RECORDS STORAGE	A	-43	OPERATION OF PLANT	7.00	0	33.63
33.64	ADVERTISING	A	-1,116	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.64
33.65	ADVERTISING	A	1,011	ADMINISTRATIVE & GENERAL	5.00	0	33.65
33.66	ADVERTISING	A	-101	MEDICAL RECORDS & LIBRARY	16.00	0	33.66
33.67	ADVERTISING	A	-250	ADULTS & PEDIATRICS	30.00	0	33.67
33.68	ADVERTISING	A	-48	SUBPROVIDER - IRF	41.00	0	33.68
33.69	ADVERTISING	A	-1,828	OPERATING ROOM	50.00	0	33.69
33.70	ADVERTISING	A	546	ENDOSCOPY	76.01	0	33.70
33.71	ADVERTISING	A	-205,827	EMERGENCY	91.00	0	33.71
33.72	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.72
33.73	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.73
33.74	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.74
33.75	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.75
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,599,325				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: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet A-8-1 Date/Time Prepared: 1/30/2019 11:15 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HPG	101,330	235,753	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	IT&S	1,880,602	1,874,416	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST	1,912,558	7,444,765	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE DIRECT COMP.	268,082	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SSC	2,815,615	2,778,791	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	SUPPLY CHAIN	1,479,935	1,472,646	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	PARALLON WORKFORCE SOLUTIONS	-2,754	-3,015	4.03
4.04	13.00	NURSING ADMINISTRATION	PARALLON WORKFORCE SOLUTIONS	186,246	203,994	4.04
4.05	30.00	ADULTS & PEDIATRICS	PARALLON WORKFORCE SOLUTIONS	1,054,020	1,154,457	4.05
4.06	31.00	INTENSIVE CARE UNIT	PARALLON WORKFORCE SOLUTIONS	80,635	88,319	4.06
4.07	41.00	SUBPROVIDER - IRF	PARALLON WORKFORCE SOLUTIONS	-1,429	-1,565	4.07
4.08	50.00	OPERATING ROOM	PARALLON WORKFORCE SOLUTIONS	54,023	59,171	4.08
4.09	51.00	RECOVERY ROOM	PARALLON WORKFORCE SOLUTIONS	702	769	4.09
4.10	52.00	DELIVERY ROOM & LABOR ROOM	PARALLON WORKFORCE SOLUTIONS	185,068	202,703	4.10
4.11	59.00	CARDIAC CATHETERIZATION	PARALLON WORKFORCE SOLUTIONS	37,926	41,540	4.11
4.12	71.00	MEDICAL SUPPLIES CHARGED TO	PARALLON WORKFORCE SOLUTIONS	2,983	3,267	4.12
4.13	91.00	EMERGENCY	PARALLON WORKFORCE SOLUTIONS	265,210	290,482	4.13
4.14	194.02	SITTERS	PARALLON WORKFORCE SOLUTIONS	507	555	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	PARALLON MARK-UP	0	748,247	4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	PARALLON PAYROLL	18,790	35,665	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	CAPITAL DIVISION IT&S	1,242,202	1,278,436	4.17
4.18	16.00	MEDICAL RECORDS & LIBRARY	HIM	1,026,308	986,423	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	REVENUE INTEGRITY	106,828	98,425	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	CREDENTIALING	73,848	74,036	4.20
4.21	40.00	SUBPROVIDER - IPF	BEHAVIORAL HEALTH	93,018	111,692	4.21
4.22	5.00	ADMINISTRATIVE & GENERAL	IT&S PARALLON	378,481	378,481	4.22
4.23	16.00	MEDICAL RECORDS & LIBRARY	PREBILL DENIAL	29,484	26,387	4.23
4.24	4.00	EMPLOYEE BENEFITS DEPARTMENT	HCA HR SERVICES	586,853	567,629	4.24
4.25	5.00	ADMINISTRATIVE & GENERAL	OTHER FUNCTIONAL	229,855	229,855	4.25
4.26	7.00	OPERATION OF PLANT	CAD STORAGE	33	33	4.26
4.27	5.00	ADMINISTRATIVE & GENERAL	CALL CENTER	0	71,301	4.27
4.28	5.00	ADMINISTRATIVE & GENERAL	PHYSICIAN RECRUITING	0	88,800	4.28
4.29	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	653,013	963,283	4.29
4.30	5.00	ADMINISTRATIVE & GENERAL	GENERAL LIABILITY INSURANCE	0	13,964	4.30
4.31	5.00	ADMINISTRATIVE & GENERAL	PHYSICIAN SALES	0	240,750	4.31
4.32	5.00	ADMINISTRATIVE & GENERAL	MARKETING ALLOCATIONS	0	170,112	4.32
4.33	5.00	ADMINISTRATIVE & GENERAL	RICHMOND FSC	206,052	210,925	4.33
4.34	4.00	EMPLOYEE BENEFITS DEPARTMENT	RESTORATION PLAN EXP.	0	5,109	4.34
4.35	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INS_POOLING ADJ.	0	-332,225	4.35
4.36	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY INTEREST	0	-14,134,439	4.36
4.37	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST	570,061	0	4.37
4.38	1.00	CAP REL COSTS-BLDG & FIXT	POB SPACE	29,012	0	4.38
4.39	5.00	ADMINISTRATIVE & GENERAL	POB SPACE	21,426	0	4.39
4.40	7.00	OPERATION OF PLANT	POB SPACE	44,558	0	4.40
4.41	9.00	HOUSEKEEPING	POB SPACE	5,760	0	4.41
4.42	1.00	CAP REL COSTS-BLDG & FIXT	PAVILLION SPACE	189,433	0	4.42
4.43	5.00	ADMINISTRATIVE & GENERAL	PAVILLION SPACE	2,076	0	4.43
4.44	7.00	OPERATION OF PLANT	PAVILLION SPACE	72,921	0	4.44
4.45	9.00	HOUSEKEEPING	PAVILLION SPACE	14,833	0	4.45
4.46	0.00			0	0	4.46
4.47	0.00			0	0	4.47
4.48	0.00			0	0	4.48
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			15,916,104	7,679,937	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:					

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

Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 1/30/2019 11:15 am

				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	

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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		100.00	PARALLON	100.00	6.00
7.00	B		55.08	HPG	55.08	7.00
8.00	B		100.00	HCI	100.00	8.00
9.00	B		100.00	CAPITAL DIVISIO	100.00	9.00
10.00	B		100.00	WORKFORCE MGT.	100.00	10.00
10.01	B		100.00	HCA	100.00	10.01
10.02	B		100.00	POB	100.00	10.02
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: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-8-1 Date/Time Prepared: 1/30/2019 11:15 am

	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	-134,423	0	1.00
2.00	6,186	0	2.00
3.00	-5,532,207	0	3.00
4.00	268,082	0	4.00
4.01	36,824	0	4.01
4.02	7,289	0	4.02
4.03	261	0	4.03
4.04	-17,748	0	4.04
4.05	-100,437	0	4.05
4.06	-7,684	0	4.06
4.07	136	0	4.07
4.08	-5,148	0	4.08
4.09	-67	0	4.09
4.10	-17,635	0	4.10
4.11	-3,614	0	4.11
4.12	-284	0	4.12
4.13	-25,272	0	4.13
4.14	-48	0	4.14
4.15	-748,247	0	4.15
4.16	-16,875	0	4.16
4.17	-36,234	0	4.17
4.18	39,885	0	4.18
4.19	8,403	0	4.19
4.20	-188	0	4.20
4.21	-18,674	0	4.21
4.22	0	0	4.22
4.23	3,097	0	4.23
4.24	19,224	0	4.24
4.25	0	0	4.25
4.26	0	0	4.26
4.27	-71,301	0	4.27
4.28	-88,800	0	4.28
4.29	-310,270	0	4.29
4.30	-13,964	0	4.30
4.31	-240,750	0	4.31
4.32	-170,112	0	4.32
4.33	-4,873	0	4.33
4.34	-5,109	0	4.34
4.35	332,225	0	4.35
4.36	14,134,439	0	4.36
4.37	570,061	0	4.37
4.38	29,012	9	4.38
4.39	21,426	0	4.39
4.40	44,558	0	4.40
4.41	5,760	0	4.41
4.42	189,433	9	4.42
4.43	2,076	0	4.43
4.44	72,921	0	4.44
4.45	14,833	0	4.45
4.46	0	0	4.46
4.47	0	0	4.47
4.48	0	0	4.48
5.00	8,236,167		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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 1/30/2019 11:15 am

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

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	MANAGEMENT		6.00
7.00	PURCHASING		7.00
8.00	INSURANCE		8.00
9.00	MANAGEMENT		9.00
10.00	STAFFING		10.00
10.01	HOSPITAL MGT.		10.01
10.02	PROFESSIONAL BU		10.02
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: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 1/30/2019 11:15 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,528,013	1,528,013	0	211,500	0	1.00
2.00	40.00	SUBPROVIDER - IPF	660,468	660,468	0	181,300	0	2.00
3.00	43.00	NURSERY	161,500	114,800	46,700	169,700	234	3.00
4.00	50.00	OPERATING ROOM	1,208,321	1,206,251	2,070	246,400	15	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	-56,619	-56,619	0	271,900	0	5.00
6.00	65.00	RESPIRATORY THERAPY	95,250	95,250	0	211,500	0	6.00
7.00	66.00	PHYSICAL THERAPY	86,775	21,375	65,400	211,500	436	7.00
8.00	69.00	ELECTROCARDIOLOGY	32,962	-3,001	35,963	211,500	240	8.00
9.00	76.01	ENDOSCOPY	93,100	45,100	48,000	246,400	240	9.00
10.00	76.03	WOUND CARE	36,000	0	36,000	211,500	240	10.00
11.00	76.04	OPIC	56,100	0	56,100	211,500	300	11.00
12.00	91.00	EMERGENCY	8,265,079	8,210,079	55,000	211,500	220	12.00
200.00			12,166,949	11,821,716	345,233		1,925	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	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	43.00	NURSERY	19,091	955	0	0	0	3.00
4.00	50.00	OPERATING ROOM	1,777	89	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	66.00	PHYSICAL THERAPY	44,334	2,217	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	24,404	1,220	0	0	0	8.00
9.00	76.01	ENDOSCOPY	28,431	1,422	0	0	0	9.00
10.00	76.03	WOUND CARE	24,404	1,220	0	0	0	10.00
11.00	76.04	OPIC	30,505	1,525	0	0	0	11.00
12.00	91.00	EMERGENCY	22,370	1,119	0	0	0	12.00
200.00			195,316	9,767	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	1,528,013		1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	660,468		2.00
3.00	43.00	NURSERY	0	19,091	27,609	142,409		3.00
4.00	50.00	OPERATING ROOM	0	1,777	293	1,206,544		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	-56,619		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	95,250		6.00
7.00	66.00	PHYSICAL THERAPY	0	44,334	21,066	42,441		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	24,404	11,559	8,558		8.00
9.00	76.01	ENDOSCOPY	0	28,431	19,569	64,669		9.00
10.00	76.03	WOUND CARE	0	24,404	11,596	11,596		10.00
11.00	76.04	OPIC	0	30,505	25,595	25,595		11.00
12.00	91.00	EMERGENCY	0	22,370	32,630	8,242,709		12.00
200.00			0	195,316	149,917	11,971,633		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part I Date/Time Prepared: 1/30/2019 11:15 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,558,819	3,558,819				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,526,308		3,526,308			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,301,620	16,333	16,184	8,334,137		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,394,567	325,692	322,717	1,110,286	28,153,262	5.00
7.00	00700	OPERATION OF PLANT	4,076,465	928,467	919,984	156,864	6,081,780	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	756,602	38,192	37,843	0	832,637	8.00
9.00	00900	HOUSEKEEPING	1,301,470	27,095	26,848	205,224	1,560,637	9.00
10.00	01000	DIETARY	1,517,664	56,860	56,341	28,999	1,659,864	10.00
11.00	01100	CAFETERIA	289,129	34,323	34,009	10,922	368,383	11.00
13.00	01300	NURSING ADMINISTRATION	1,003,851	11,487	11,382	170,964	1,197,684	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,072,771	8,278	8,203	3,954	1,093,206	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,402,385	552,295	547,250	1,274,356	9,776,286	30.00
31.00	03100	INTENSIVE CARE UNIT	2,484,494	113,450	112,414	450,443	3,160,801	31.00
40.00	04000	SUBPROVIDER - IPF	2,144,531	98,149	97,253	428,620	2,768,553	40.00
41.00	04100	SUBPROVIDER - IRF	952,448	92,857	92,009	196,357	1,333,671	41.00
43.00	04300	NURSERY	376,875	21,263	21,069	66,231	485,438	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,922,738	273,259	270,763	907,806	6,374,566	50.00
51.00	05100	RECOVERY ROOM	579,421	14,734	14,599	112,107	720,861	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,100,537	44,080	43,677	180,261	1,368,555	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,678,810	154,098	152,690	217,717	2,203,315	54.00
54.01	03630	ULTRA SOUND	189,692	13,971	13,843	37,227	254,733	54.01
54.02	03440	MAMMOGRAPHY	202,757	31,458	31,170	26,491	291,876	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	988,212	40,675	40,304	136,494	1,205,685	55.00
56.00	05600	RADIOISOTOPE	782,131	9,739	9,650	37,175	838,695	56.00
57.00	05700	CT SCAN	743,546	17,357	17,198	123,481	901,582	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	352,927	17,291	17,134	57,153	444,505	58.00
59.00	05900	CARDIAC CATHETERIZATION	540,747	21,328	21,133	118,383	701,591	59.00
60.00	06000	LABORATORY	2,942,393	65,622	65,023	285,762	3,358,800	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	662,576	2,911	2,885	0	668,372	62.00
65.00	06500	RESPIRATORY THERAPY	1,159,734	17,552	17,392	212,131	1,406,809	65.00
66.00	06600	PHYSICAL THERAPY	1,003,434	67,789	67,170	203,993	1,342,386	66.00
69.00	06900	ELECTROCARDIOLOGY	826,478	40,378	40,009	107,361	1,014,226	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	65,065	4,958	4,912	11,039	85,974	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,928,665	60,023	59,474	85,557	7,133,719	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,321,697	0	0	0	6,321,697	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,465,839	41,364	40,986	343,893	12,892,082	73.00
74.00	07400	RENAL DIALYSIS	536,895	9,208	9,124	16	555,243	74.00
76.00	03950	LITHOTRIPSY	231,984	0	0	0	231,984	76.00
76.01	03330	ENDOSCOPY	1,112,342	14,734	14,599	177,691	1,319,366	76.01
76.02	03040	PRISION CLINIC	157,668	41,224	40,848	32,417	272,157	76.02
76.03	03050	WOUND CARE	619,123	23,812	23,594	15,180	681,709	76.03
76.04	03060	OPIC	541,536	41,206	40,829	105,892	729,463	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,087,745	130,779	129,584	485,499	3,833,607	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)	115,904,691	3,524,291	3,492,096	8,123,946	115,625,760	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	49,597	5,265	5,217	0	60,079	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	539,268	29,263	28,995	148,163	745,689	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	0	194.01
194.02	07952	SITTERS	263,429	0	0	56,510	319,939	194.02
194.03	07953	UNLICENSED STAFF	25,610	0	0	5,518	31,128	194.03
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)	116,782,595	3,558,819	3,526,308	8,334,137	116,782,595	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part I Date/Time Prepared: 1/30/2019 11:15 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,153,262					5.00
7.00	00700	OPERATION OF PLANT	1,931,890	8,013,670				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	264,489	133,747	1,230,873			8.00
9.00	00900	HOUSEKEEPING	495,739	94,887	0	2,151,263		9.00
10.00	01000	DIETARY	527,259	199,123	0	55,024	2,441,270	10.00
11.00	01100	CAFETERIA	117,018	120,197	0	33,214	0	11.00
13.00	01300	NURSING ADMINISTRATION	380,447	40,228	0	11,116	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	347,259	28,991	0	8,011	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,105,457	1,934,124	687,311	534,463	1,024,877	30.00
31.00	03100	INTENSIVE CARE UNIT	1,004,035	397,301	138,133	109,787	79,679	31.00
40.00	04000	SUBPROVIDER - IPF	879,436	343,717	276,602	94,980	354,449	40.00
41.00	04100	SUBPROVIDER - IRF	423,643	325,183	87,785	89,859	156,073	41.00
43.00	04300	NURSERY	154,200	74,463	41,042	20,577	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,024,894	956,948	0	264,437	0	50.00
51.00	05100	RECOVERY ROOM	228,983	51,597	0	14,258	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	434,724	154,366	0	42,657	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	699,887	539,648	0	149,122	0	54.00
54.01	03630	ULTRA SOUND	80,916	48,926	0	13,520	0	54.01
54.02	03440	MAMMOGRAPHY	92,715	110,164	0	30,442	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	382,988	142,445	0	39,362	0	55.00
56.00	05600	RADIOISOTOPE	266,413	34,105	0	9,424	0	56.00
57.00	05700	CT SCAN	286,389	60,782	0	16,796	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	141,198	60,554	0	16,733	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	222,862	74,691	0	20,640	0	59.00
60.00	06000	LABORATORY	1,066,930	229,807	0	63,503	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	212,310	10,196	0	2,817	0	62.00
65.00	06500	RESPIRATORY THERAPY	446,876	61,466	0	16,985	0	65.00
66.00	06600	PHYSICAL THERAPY	426,412	237,397	0	65,601	0	66.00
69.00	06900	ELECTROCARDIOLOGY	322,171	141,402	0	39,074	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,310	17,362	0	4,798	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,266,040	210,198	0	58,085	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,008,100	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,095,173	144,855	0	40,028	0	73.00
74.00	07400	RENAL DIALYSIS	176,374	32,248	0	8,911	0	74.00
76.00	03950	LITHOTRIPSY	73,690	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	419,099	51,597	0	14,258	0	76.01
76.02	03040	PRISION CLINIC	86,451	144,366	0	39,893	0	76.02
76.03	03050	WOUND CARE	216,546	83,389	0	23,043	0	76.03
76.04	03060	OPIC	231,715	144,301	0	39,875	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,217,753	457,985	0	126,557	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)	27,785,791	7,892,756	1,230,873	2,117,850	1,615,078	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,084	18,437	0	5,095	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	236,870	102,477	0	28,318	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	826,192	194.01
194.02	07952	SITTERS	101,629	0	0	0	0	194.02
194.03	07953	UNLICENSED STAFF	9,888	0	0	0	0	194.03
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)	28,153,262	8,013,670	1,230,873	2,151,263	2,441,270	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part I Date/Time Prepared: 1/30/2019 11:15 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	638,812					11.00
13.00	01300	NURSING ADMINISTRATION	16,010	1,645,485				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	370	0	1,477,837			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	119,326	644,797	42,764	17,869,405	0	30.00
31.00	03100	INTENSIVE CARE UNIT	42,181	224,107	19,406	5,175,430	0	31.00
40.00	04000	SUBPROVIDER - IPF	40,137	116,677	49,477	4,924,028	0	40.00
41.00	04100	SUBPROVIDER - IRF	18,387	79,602	5,362	2,519,565	0	41.00
43.00	04300	NURSERY	6,202	34,204	3,861	819,987	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	85,010	254,764	206,251	10,166,870	0	50.00
51.00	05100	RECOVERY ROOM	10,498	52,791	27,372	1,106,360	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,880	96,428	9,085	2,122,695	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,388	0	28,181	3,640,541	0	54.00
54.01	03630	ULTRA SOUND	3,486	0	9,853	411,434	0	54.01
54.02	03440	MAMMOGRAPHY	2,481	0	3,792	531,470	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	12,782	0	31,032	1,814,294	0	55.00
56.00	05600	RADIOISOTOPE	3,481	0	23,642	1,175,760	0	56.00
57.00	05700	CT SCAN	11,563	0	106,974	1,384,086	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,352	0	24,184	692,526	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	11,086	24,537	49,146	1,104,553	0	59.00
60.00	06000	LABORATORY	26,760	0	141,181	4,886,981	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	11,840	905,535	0	62.00
65.00	06500	RESPIRATORY THERAPY	19,865	0	34,504	1,986,505	0	65.00
66.00	06600	PHYSICAL THERAPY	19,103	37	13,368	2,104,304	0	66.00
69.00	06900	ELECTROCARDIOLOGY	10,054	14,235	37,674	1,578,836	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,034	0	2,627	139,105	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,012	923	94,446	9,771,423	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	50,333	8,380,130	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,203	0	222,859	17,427,200	0	73.00
74.00	07400	RENAL DIALYSIS	1	0	8,147	780,924	0	74.00
76.00	03950	LITHOTRIPSY	0	0	6,225	311,899	0	76.00
76.01	03330	ENDOSCOPY	16,640	68,575	72,464	1,961,999	0	76.01
76.02	03040	PRISION CLINIC	3,036	0	1,137	547,040	0	76.02
76.03	03050	WOUND CARE	1,421	0	4,617	1,010,725	0	76.03
76.04	03060	OPIC	9,916	31,658	11,470	1,198,398	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	45,464	0	124,563	5,805,929	0	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)	619,129	1,643,335	1,477,837	114,255,937	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	102,695	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	13,874	0	0	1,127,228	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	826,192	0	194.01
194.02	07952	SITTERS	5,292	2,150	0	429,010	0	194.02
194.03	07953	UNLICENSED STAFF	517	0	0	41,533	0	194.03
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)	638,812	1,645,485	1,477,837	116,782,595	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part I | Date/Time Prepared: 1/30/2019 11:15 am

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	17,869,405	30.00
31.00	03100	INTENSIVE CARE UNIT	5,175,430	31.00
40.00	04000	SUBPROVIDER - IPF	4,924,028	40.00
41.00	04100	SUBPROVIDER - IRF	2,519,565	41.00
43.00	04300	NURSERY	819,987	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	10,166,870	50.00
51.00	05100	RECOVERY ROOM	1,106,360	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,122,695	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,640,541	54.00
54.01	03630	ULTRA SOUND	411,434	54.01
54.02	03440	MAMMOGRAPHY	531,470	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,814,294	55.00
56.00	05600	RADIOISOTOPE	1,175,760	56.00
57.00	05700	CT SCAN	1,384,086	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	692,526	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,104,553	59.00
60.00	06000	LABORATORY	4,886,981	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	905,535	62.00
65.00	06500	RESPIRATORY THERAPY	1,986,505	65.00
66.00	06600	PHYSICAL THERAPY	2,104,304	66.00
69.00	06900	ELECTROCARDIOLOGY	1,578,836	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	139,105	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,771,423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,380,130	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,427,200	73.00
74.00	07400	RENAL DIALYSIS	780,924	74.00
76.00	03950	LITHOTRIPSY	311,899	76.00
76.01	03330	ENDOSCOPY	1,961,999	76.01
76.02	03040	PRISION CLINIC	547,040	76.02
76.03	03050	WOUND CARE	1,010,725	76.03
76.04	03060	OPIC	1,198,398	76.04
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	5,805,929	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)	114,255,937	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	102,695	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	1,127,228	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	826,192	194.01
194.02	07952	SITTERS	429,010	194.02
194.03	07953	UNLICENSED STAFF	41,533	194.03
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	116,782,595	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part II | Date/Time Prepared: 1/30/2019 11:15 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			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	16,333	16,184	32,517	32,517	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,339,840	325,692	322,717	2,988,249	4,330	5.00
7.00	00700	OPERATION OF PLANT	0	928,467	919,984	1,848,451	612	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	38,192	37,843	76,035	0	8.00
9.00	00900	HOUSEKEEPING	0	27,095	26,848	53,943	800	9.00
10.00	01000	DIETARY	0	56,860	56,341	113,201	113	10.00
11.00	01100	CAFETERIA	0	34,323	34,009	68,332	43	11.00
13.00	01300	NURSING ADMINISTRATION	1,098	11,487	11,382	23,967	667	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,377	8,278	8,203	26,858	15	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,218	552,295	547,250	1,105,763	4,987	30.00
31.00	03100	INTENSIVE CARE UNIT	476	113,450	112,414	226,340	1,757	31.00
40.00	04000	SUBPROVIDER - IPF	0	98,149	97,253	195,402	1,671	40.00
41.00	04100	SUBPROVIDER - IRF	-8	92,857	92,009	184,858	766	41.00
43.00	04300	NURSERY	0	21,263	21,069	42,332	258	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	319	273,259	270,763	544,341	3,540	50.00
51.00	05100	RECOVERY ROOM	4	14,734	14,599	29,337	437	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,092	44,080	43,677	88,849	703	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	154,098	152,690	306,788	849	54.00
54.01	03630	ULTRA SOUND	0	13,971	13,843	27,814	145	54.01
54.02	03440	MAMMOGRAPHY	0	31,458	31,170	62,628	103	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	40,675	40,304	80,979	532	55.00
56.00	05600	RADIOISOTOPE	0	9,739	9,650	19,389	145	56.00
57.00	05700	CT SCAN	0	17,357	17,198	34,555	482	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	17,291	17,134	34,425	223	58.00
59.00	05900	CARDIAC CATHETERIZATION	224	21,328	21,133	42,685	462	59.00
60.00	06000	LABORATORY	0	65,622	65,023	130,645	1,114	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,911	2,885	5,796	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	17,552	17,392	34,944	827	65.00
66.00	06600	PHYSICAL THERAPY	0	67,789	67,170	134,959	795	66.00
69.00	06900	ELECTROCARDIOLOGY	0	40,378	40,009	80,387	419	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,958	4,912	9,870	43	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18	60,023	59,474	119,515	334	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	41,364	40,986	82,350	1,341	73.00
74.00	07400	RENAL DIALYSIS	0	9,208	9,124	18,332	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	14,734	14,599	29,333	693	76.01
76.02	03040	PRISION CLINIC	0	41,224	40,848	82,072	126	76.02
76.03	03050	WOUND CARE	0	23,812	23,594	47,406	59	76.03
76.04	03060	OPIC	0	41,206	40,829	82,035	413	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,565	130,779	129,584	261,928	1,893	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,361,223	3,524,291	3,492,096	9,377,610	31,697	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,265	5,217	10,482	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	0	29,263	28,995	58,258	578	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	0	194.01
194.02	07952	SITTERS	3	0	0	3	220	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	22	194.03
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)	2,361,226	3,558,819	3,526,308	9,446,353	32,517	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part II Date/Time Prepared: 1/30/2019 11:15 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,992,579					5.00
7.00	00700	OPERATION OF PLANT	205,351	2,054,414				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,114	34,288	138,437			8.00
9.00	00900	HOUSEKEEPING	52,695	24,326	0	131,764		9.00
10.00	01000	DIETARY	56,045	51,048	0	3,370	223,777	10.00
11.00	01100	CAFETERIA	12,438	30,814	0	2,034	0	11.00
13.00	01300	NURSING ADMINISTRATION	40,440	10,313	0	681	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,912	7,432	0	491	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	330,096	495,838	77,302	32,735	93,945	30.00
31.00	03100	INTENSIVE CARE UNIT	106,724	101,853	15,536	6,724	7,304	31.00
40.00	04000	SUBPROVIDER - IPF	93,480	88,117	31,110	5,818	32,490	40.00
41.00	04100	SUBPROVIDER - IRF	45,031	83,365	9,873	5,504	14,306	41.00
43.00	04300	NURSERY	16,391	19,090	4,616	1,260	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	215,237	245,327	0	16,197	0	50.00
51.00	05100	RECOVERY ROOM	24,340	13,228	0	873	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,209	39,574	0	2,613	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,395	138,346	0	9,134	0	54.00
54.01	03630	ULTRA SOUND	8,601	12,543	0	828	0	54.01
54.02	03440	MAMMOGRAPHY	9,855	28,242	0	1,865	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	40,710	36,518	0	2,411	0	55.00
56.00	05600	RADIOISOTOPE	28,319	8,743	0	577	0	56.00
57.00	05700	CT SCAN	30,442	15,582	0	1,029	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,009	15,524	0	1,025	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	23,689	19,148	0	1,264	0	59.00
60.00	06000	LABORATORY	113,410	58,914	0	3,890	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	22,568	2,614	0	173	0	62.00
65.00	06500	RESPIRATORY THERAPY	47,501	15,758	0	1,040	0	65.00
66.00	06600	PHYSICAL THERAPY	45,326	60,860	0	4,018	0	66.00
69.00	06900	ELECTROCARDIOLOGY	34,245	36,250	0	2,393	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,903	4,451	0	294	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	240,870	53,887	0	3,558	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	213,452	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	435,312	37,136	0	2,452	0	73.00
74.00	07400	RENAL DIALYSIS	18,748	8,267	0	546	0	74.00
76.00	03950	LITHOTRIPSY	7,833	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	44,548	13,228	0	873	0	76.01
76.02	03040	PRISION CLINIC	9,189	37,010	0	2,443	0	76.02
76.03	03050	WOUND CARE	23,018	21,378	0	1,411	0	76.03
76.04	03060	OPIC	24,630	36,994	0	2,442	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	129,442	117,411	0	7,752	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)	2,953,518	2,023,417	138,437	129,718	148,045	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,029	4,726	0	312	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	25,178	26,271	0	1,734	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	75,732	194.01
194.02	07952	SITTERS	10,803	0	0	0	0	194.02
194.03	07953	UNLICENSED STAFF	1,051	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,992,579	2,054,414	138,437	131,764	223,777	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part II | Date/Time Prepared: 1/30/2019 11:15 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	113,661					11.00
13.00	01300	NURSING ADMINISTRATION	2,848	78,916				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	66	0	71,774			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,238	30,924	2,084	2,194,912	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,505	10,748	946	485,437	0	31.00
40.00	04000	SUBPROVIDER - IPF	7,141	5,596	2,412	463,237	0	40.00
41.00	04100	SUBPROVIDER - IRF	3,271	3,818	261	351,053	0	41.00
43.00	04300	NURSERY	1,103	1,640	188	86,878	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,125	12,218	10,053	1,062,038	0	50.00
51.00	05100	RECOVERY ROOM	1,868	2,532	1,334	73,949	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,003	4,624	443	186,018	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,627	0	1,374	534,513	0	54.00
54.01	03630	ULTRA SOUND	620	0	480	51,031	0	54.01
54.02	03440	MAMMOGRAPHY	441	0	185	103,319	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	2,274	0	1,513	164,937	0	55.00
56.00	05600	RADIOISOTOPE	619	0	1,152	58,944	0	56.00
57.00	05700	CT SCAN	2,057	0	5,214	89,361	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	952	0	1,179	68,337	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,972	1,177	2,395	92,792	0	59.00
60.00	06000	LABORATORY	4,761	0	6,881	319,615	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	577	31,728	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,534	0	1,682	105,286	0	65.00
66.00	06600	PHYSICAL THERAPY	3,399	2	652	250,011	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,789	683	1,836	158,002	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	184	0	128	17,873	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,425	44	4,603	424,236	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,453	215,905	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,730	0	10,607	574,928	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	397	46,290	0	74.00
76.00	03950	LITHOTRIPSY	0	0	303	8,136	0	76.00
76.01	03330	ENDOSCOPY	2,960	3,289	3,532	98,456	0	76.01
76.02	03040	PRISION CLINIC	540	0	55	131,435	0	76.02
76.03	03050	WOUND CARE	253	0	225	93,750	0	76.03
76.04	03060	OPIC	1,764	1,518	559	150,355	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,089	0	6,071	532,586	0	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)	110,158	78,813	71,774	9,225,348	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	17,549	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	2,469	0	0	114,488	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	75,732	0	194.01
194.02	07952	SITTERS	942	103	0	12,071	0	194.02
194.03	07953	UNLICENSED STAFF	92	0	0	1,165	0	194.03
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)	113,661	78,916	71,774	9,446,353	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part II | Date/Time Prepared: 1/30/2019 11:15 am

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	2,194,912	30.00
31.00	03100	INTENSIVE CARE UNIT	485,437	31.00
40.00	04000	SUBPROVIDER - IPF	463,237	40.00
41.00	04100	SUBPROVIDER - IRF	351,053	41.00
43.00	04300	NURSERY	86,878	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	1,062,038	50.00
51.00	05100	RECOVERY ROOM	73,949	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,018	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	534,513	54.00
54.01	03630	ULTRA SOUND	51,031	54.01
54.02	03440	MAMMOGRAPHY	103,319	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	164,937	55.00
56.00	05600	RADIOISOTOPE	58,944	56.00
57.00	05700	CT SCAN	89,361	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	68,337	58.00
59.00	05900	CARDIAC CATHETERIZATION	92,792	59.00
60.00	06000	LABORATORY	319,615	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,728	62.00
65.00	06500	RESPIRATORY THERAPY	105,286	65.00
66.00	06600	PHYSICAL THERAPY	250,011	66.00
69.00	06900	ELECTROCARDIOLOGY	158,002	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,873	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	424,236	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	215,905	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	574,928	73.00
74.00	07400	RENAL DIALYSIS	46,290	74.00
76.00	03950	LITHOTRIPSY	8,136	76.00
76.01	03330	ENDOSCOPY	98,456	76.01
76.02	03040	PRISION CLINIC	131,435	76.02
76.03	03050	WOUND CARE	93,750	76.03
76.04	03060	OPIC	150,355	76.04
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	532,586	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)	9,225,348	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,549	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	114,488	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	75,732	194.01
194.02	07952	SITTERS	12,071	194.02
194.03	07953	UNLICENSED STAFF	1,165	194.03
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,446,353	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/30/2019 11:15 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET 2)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	382,607					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		382,607				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,756	1,756	35,991,303			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,015	35,015	4,794,807	-28,153,262	88,629,333	5.00
7.00	00700	OPERATION OF PLANT	99,819	99,819	677,421	0	6,081,780	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,106	4,106	0	0	832,637	8.00
9.00	00900	HOUSEKEEPING	2,913	2,913	886,265	0	1,560,637	9.00
10.00	01000	DIETARY	6,113	6,113	125,235	0	1,659,864	10.00
11.00	01100	CAFETERIA	3,690	3,690	47,169	0	368,383	11.00
13.00	01300	NURSING ADMINISTRATION	1,235	1,235	738,312	0	1,197,684	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	890	890	17,075	0	1,093,206	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,377	59,377	5,503,403	0	9,776,286	30.00
31.00	03100	INTENSIVE CARE UNIT	12,197	12,197	1,945,252	0	3,160,801	31.00
40.00	04000	SUBPROVIDER - IPF	10,552	10,552	1,851,011	0	2,768,553	40.00
41.00	04100	SUBPROVIDER - IRF	9,983	9,983	847,975	0	1,333,671	41.00
43.00	04300	NURSERY	2,286	2,286	286,019	0	485,438	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,378	29,378	3,920,392	0	6,374,566	50.00
51.00	05100	RECOVERY ROOM	1,584	1,584	484,139	0	720,861	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,739	4,739	778,465	0	1,368,555	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,567	16,567	940,218	0	2,203,315	54.00
54.01	03630	ULTRA SOUND	1,502	1,502	160,765	0	254,733	54.01
54.02	03440	MAMMOGRAPHY	3,382	3,382	114,401	0	291,876	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	4,373	4,373	589,454	0	1,205,685	55.00
56.00	05600	RADIOISOTOPE	1,047	1,047	160,543	0	838,695	56.00
57.00	05700	CT SCAN	1,866	1,866	533,257	0	901,582	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,859	1,859	246,816	0	444,505	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,293	2,293	511,239	0	701,591	59.00
60.00	06000	LABORATORY	7,055	7,055	1,234,073	0	3,358,800	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	313	313	0	0	668,372	62.00
65.00	06500	RESPIRATORY THERAPY	1,887	1,887	916,094	0	1,406,809	65.00
66.00	06600	PHYSICAL THERAPY	7,288	7,288	880,950	0	1,342,386	66.00
69.00	06900	ELECTROCARDIOLOGY	4,341	4,341	463,642	0	1,014,226	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	533	533	47,673	0	85,974	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,453	6,453	369,480	0	7,133,719	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,321,697	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,447	4,447	1,485,116	0	12,892,082	73.00
74.00	07400	RENAL DIALYSIS	990	990	68	0	555,243	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	231,984	76.00
76.01	03330	ENDOSCOPY	1,584	1,584	767,364	0	1,319,366	76.01
76.02	03040	PRISION CLINIC	4,432	4,432	139,992	0	272,157	76.02
76.03	03050	WOUND CARE	2,560	2,560	65,555	0	681,709	76.03
76.04	03060	OPIC	4,430	4,430	457,297	0	729,463	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	14,060	14,060	2,096,644	0	3,833,607	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)	378,895	378,895	35,083,581	-28,153,262	87,472,498	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	566	566	0	0	60,079	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	3,146	3,146	639,849	0	745,689	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	0	194.01
194.02	07952	SITTERS	0	0	244,042	0	319,939	194.02
194.03	07953	UNLICENSED STAFF	0	0	23,831	0	31,128	194.03
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)	3,558,819	3,526,308	8,334,137		28,153,262	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.301500	9.216528	0.231560		0.317652	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			32,517		2,992,579	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000903		0.033765	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/30/2019 11:15 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET 2)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/30/2019 11:15 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET 2)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	246,017					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,106	29,361				8.00
9.00	00900	HOUSEKEEPING	2,913	0	238,998			9.00
10.00	01000	DIETARY	6,113	0	6,113	142,654		10.00
11.00	01100	CAFETERIA	3,690	0	3,690	0	29,460,406	11.00
13.00	01300	NURSING ADMINISTRATION	1,235	0	1,235	0	738,312	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	890	0	890	0	17,075	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,377	16,395	59,377	59,888	5,503,403	30.00
31.00	03100	INTENSIVE CARE UNIT	12,197	3,295	12,197	4,656	1,945,252	31.00
40.00	04000	SUBPROVIDER - IPF	10,552	6,598	10,552	20,712	1,851,011	40.00
41.00	04100	SUBPROVIDER - IRF	9,983	2,094	9,983	9,120	847,975	41.00
43.00	04300	NURSERY	2,286	979	2,286	0	286,019	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,378	0	29,378	0	3,920,392	50.00
51.00	05100	RECOVERY ROOM	1,584	0	1,584	0	484,139	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,739	0	4,739	0	778,465	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,567	0	16,567	0	940,218	54.00
54.01	03630	ULTRA SOUND	1,502	0	1,502	0	160,765	54.01
54.02	03440	MAMMOGRAPHY	3,382	0	3,382	0	114,401	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	4,373	0	4,373	0	589,454	55.00
56.00	05600	RADIOISOTOPE	1,047	0	1,047	0	160,543	56.00
57.00	05700	CT SCAN	1,866	0	1,866	0	533,257	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,859	0	1,859	0	246,816	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,293	0	2,293	0	511,239	59.00
60.00	06000	LABORATORY	7,055	0	7,055	0	1,234,073	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	313	0	313	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,887	0	1,887	0	916,094	65.00
66.00	06600	PHYSICAL THERAPY	7,288	0	7,288	0	880,950	66.00
69.00	06900	ELECTROCARDIOLOGY	4,341	0	4,341	0	463,642	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	533	0	533	0	47,673	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,453	0	6,453	0	369,480	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,447	0	4,447	0	1,485,116	73.00
74.00	07400	RENAL DIALYSIS	990	0	990	0	68	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	1,584	0	1,584	0	767,364	76.01
76.02	03040	PRISION CLINIC	4,432	0	4,432	0	139,992	76.02
76.03	03050	WOUND CARE	2,560	0	2,560	0	65,555	76.03
76.04	03060	OPIC	4,430	0	4,430	0	457,297	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	14,060	0	14,060	0	2,096,644	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)	242,305	29,361	235,286	94,376	28,552,684	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	566	0	566	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	3,146	0	3,146	0	639,849	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	48,278	0	194.01
194.02	07952	SITTERS	0	0	0	0	244,042	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	23,831	194.03
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)	8,013,670	1,230,873	2,151,263	2,441,270	638,812	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.573643	41.922039	9.001176	17.113225	0.021684	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,054,414	138,437	131,764	223,777	113,661	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.350699	4.714996	0.551318	1.568670	0.003858	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: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/30/2019 11:15 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			13.00	16.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION	12,563,787		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	774,409,765	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	4,923,183	22,412,817	30.00
31.00	03100	INTENSIVE CARE UNIT	1,711,129	10,170,730	31.00
40.00	04000	SUBPROVIDER - IPF	890,868	25,931,452	40.00
41.00	04100	SUBPROVIDER - IRF	607,789	2,810,229	41.00
43.00	04300	NURSERY	261,162	2,023,695	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,945,210	108,098,050	50.00
51.00	05100	RECOVERY ROOM	403,080	14,346,017	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	736,262	4,761,754	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,769,853	54.00
54.01	03630	ULTRA SOUND	0	5,164,080	54.01
54.02	03440	MAMMOGRAPHY	0	1,987,527	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	16,264,193	55.00
56.00	05600	RADIOISOTOPE	0	12,391,103	56.00
57.00	05700	CT SCAN	0	56,065,827	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12,674,794	58.00
59.00	05900	CARDIAC CATHETERIZATION	187,347	25,757,934	59.00
60.00	06000	LABORATORY	0	73,994,218	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	6,205,675	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,083,936	65.00
66.00	06600	PHYSICAL THERAPY	286	7,006,479	66.00
69.00	06900	ELECTROCARDIOLOGY	108,692	19,745,264	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,376,633	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,046	49,499,941	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	26,380,181	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	116,663,884	73.00
74.00	07400	RENAL DIALYSIS	0	4,269,713	74.00
76.00	03950	LITHOTRIPSY	0	3,262,674	76.00
76.01	03330	ENDOSCOPY	523,597	37,978,885	76.01
76.02	03040	PRISION CLINIC	0	596,060	76.02
76.03	03050	WOUND CARE	0	2,419,924	76.03
76.04	03060	OPIC	241,719	6,011,486	76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	65,284,757	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)	12,547,370	774,409,765	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	0	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	194.01
194.02	07952	SITTERS	16,417	0	194.02
194.03	07953	UNLICENSED STAFF	0	0	194.03
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,645,485	1,477,837	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.130970	0.001908	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	78,916	71,774	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006281	0.000093	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: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I | Date/Time Prepared: 1/30/2019 11:15 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,869,405		17,869,405	0	17,869,405	30.00
31.00	03100	INTENSIVE CARE UNIT	5,175,430		5,175,430	0	5,175,430	31.00
40.00	04000	SUBPROVIDER - IPF	4,924,028		4,924,028	0	4,924,028	40.00
41.00	04100	SUBPROVIDER - IRF	2,519,565		2,519,565	0	2,519,565	41.00
43.00	04300	NURSERY	819,987		819,987	27,609	847,596	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,166,870		10,166,870	293	10,167,163	50.00
51.00	05100	RECOVERY ROOM	1,106,360		1,106,360	0	1,106,360	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,122,695		2,122,695	0	2,122,695	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,640,541		3,640,541	0	3,640,541	54.00
54.01	03630	ULTRA SOUND	411,434		411,434	0	411,434	54.01
54.02	03440	MAMMOGRAPHY	531,470		531,470	0	531,470	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,814,294		1,814,294	0	1,814,294	55.00
56.00	05600	RADIOISOTOPE	1,175,760		1,175,760	0	1,175,760	56.00
57.00	05700	CT SCAN	1,384,086		1,384,086	0	1,384,086	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	692,526		692,526	0	692,526	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,104,553		1,104,553	0	1,104,553	59.00
60.00	06000	LABORATORY	4,886,981		4,886,981	0	4,886,981	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	905,535		905,535	0	905,535	62.00
65.00	06500	RESPIRATORY THERAPY	1,986,505	0	1,986,505	0	1,986,505	65.00
66.00	06600	PHYSICAL THERAPY	2,104,304	0	2,104,304	21,066	2,125,370	66.00
69.00	06900	ELECTROCARDIOLOGY	1,578,836		1,578,836	11,559	1,590,395	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	139,105		139,105	0	139,105	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,771,423		9,771,423	0	9,771,423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,380,130		8,380,130	0	8,380,130	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,427,200		17,427,200	0	17,427,200	73.00
74.00	07400	RENAL DIALYSIS	780,924		780,924	0	780,924	74.00
76.00	03950	LITHOTRIPSY	311,899		311,899	0	311,899	76.00
76.01	03330	ENDOSCOPY	1,961,999		1,961,999	19,569	1,981,568	76.01
76.02	03040	PRISION CLINIC	547,040		547,040	0	547,040	76.02
76.03	03050	WOUND CARE	1,010,725		1,010,725	11,596	1,022,321	76.03
76.04	03060	OPIC	1,198,398		1,198,398	25,595	1,223,993	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,805,929		5,805,929	32,630	5,838,559	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,868,045		1,868,045		1,868,045	92.00
200.00		Subtotal (see instructions)	116,123,982	0	116,123,982	149,917	116,273,899	200.00
201.00		Less Observation Beds	1,868,045		1,868,045		1,868,045	201.00
202.00		Total (see instructions)	114,255,937	0	114,255,937	149,917	114,405,854	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I Date/Time Prepared: 1/30/2019 11:15 am

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		Cost Center Description	Charges					
			Inpatient	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	20,487,222		20,487,222			30.00
31.00	03100	INTENSIVE CARE UNIT	10,170,730		10,170,730			31.00
40.00	04000	SUBPROVIDER - IPF	25,931,452		25,931,452			40.00
41.00	04100	SUBPROVIDER - IRF	2,810,229		2,810,229			41.00
43.00	04300	NURSERY	2,023,695		2,023,695			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	53,564,008	54,534,042	108,098,050	0.094052	0.000000	50.00
51.00	05100	RECOVERY ROOM	5,640,970	8,705,047	14,346,017	0.077120	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,466,522	295,232	4,761,754	0.445780	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,605,323	10,164,530	14,769,853	0.246485	0.000000	54.00
54.01	03630	ULTRA SOUND	1,320,056	3,844,024	5,164,080	0.079672	0.000000	54.01
54.02	03440	MAMMOGRAPHY	3,390	1,984,137	1,987,527	0.267403	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	884,598	15,379,595	16,264,193	0.111551	0.000000	55.00
56.00	05600	RADIOISOTOPE	1,099,026	11,292,077	12,391,103	0.094887	0.000000	56.00
57.00	05700	CT SCAN	18,327,303	37,738,524	56,065,827	0.024687	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,781,637	8,893,157	12,674,794	0.054638	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,008,804	12,749,130	25,757,934	0.042882	0.000000	59.00
60.00	06000	LABORATORY	33,076,895	40,917,323	73,994,218	0.066045	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,939,004	1,266,671	6,205,675	0.145920	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	16,944,931	1,139,005	18,083,936	0.109849	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,740,674	265,805	7,006,479	0.300337	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	10,960,713	8,784,551	19,745,264	0.079960	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	550,549	826,084	1,376,633	0.101047	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,142,049	20,357,892	49,499,941	0.197403	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,956,821	12,423,360	26,380,181	0.317668	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,450,818	51,213,066	116,663,884	0.149380	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,178,788	90,925	4,269,713	0.182898	0.000000	74.00
76.00	03950	LITHOTRIPSY	60,830	3,201,844	3,262,674	0.095596	0.000000	76.00
76.01	03330	ENDOSCOPY	3,540,340	34,438,545	37,978,885	0.051660	0.000000	76.01
76.02	03040	PRISION CLINIC	3,291	592,769	596,060	0.917760	0.000000	76.02
76.03	03050	WOUND CARE	43,823	2,376,101	2,419,924	0.417668	0.000000	76.03
76.04	03060	OPIC	28,272	5,983,214	6,011,486	0.199351	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	19,975,229	45,309,528	65,284,757	0.088932	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	410,068	1,515,527	1,925,595	0.970113	0.000000	92.00
200.00		Subtotal (see instructions)	378,128,060	396,281,705	774,409,765			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	378,128,060	396,281,705	774,409,765			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I Date/Time Prepared: 1/30/2019 11:15 am

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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
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.094055	50.00
51.00	05100	RECOVERY ROOM	0.077120	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.445780	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246485	54.00
54.01	03630	ULTRA SOUND	0.079672	54.01
54.02	03440	MAMMOGRAPHY	0.267403	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.111551	55.00
56.00	05600	RADIOISOTOPE	0.094887	56.00
57.00	05700	CT SCAN	0.024687	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.054638	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.042882	59.00
60.00	06000	LABORATORY	0.066045	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.145920	62.00
65.00	06500	RESPIRATORY THERAPY	0.109849	65.00
66.00	06600	PHYSICAL THERAPY	0.303344	66.00
69.00	06900	ELECTROCARDIOLOGY	0.080546	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.101047	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.197403	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317668	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.149380	73.00
74.00	07400	RENAL DIALYSIS	0.182898	74.00
76.00	03950	LITHOTRIPSY	0.095596	76.00
76.01	03330	ENDOSCOPY	0.052176	76.01
76.02	03040	PRISION CLINIC	0.917760	76.02
76.03	03050	WOUND CARE	0.422460	76.03
76.04	03060	OPIC	0.203609	76.04
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.089432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.970113	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: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
					Costs			
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,869,405		17,869,405	0	17,869,405	30.00
31.00	03100	INTENSIVE CARE UNIT	5,175,430		5,175,430	0	5,175,430	31.00
40.00	04000	SUBPROVIDER - IPF	4,924,028		4,924,028	0	4,924,028	40.00
41.00	04100	SUBPROVIDER - IRF	2,519,565		2,519,565	0	2,519,565	41.00
43.00	04300	NURSERY	819,987		819,987	27,609	847,596	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,166,870		10,166,870	293	10,167,163	50.00
51.00	05100	RECOVERY ROOM	1,106,360		1,106,360	0	1,106,360	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,122,695		2,122,695	0	2,122,695	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,640,541		3,640,541	0	3,640,541	54.00
54.01	03630	ULTRA SOUND	411,434		411,434	0	411,434	54.01
54.02	03440	MAMMOGRAPHY	531,470		531,470	0	531,470	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,814,294		1,814,294	0	1,814,294	55.00
56.00	05600	RADIOISOTOPE	1,175,760		1,175,760	0	1,175,760	56.00
57.00	05700	CT SCAN	1,384,086		1,384,086	0	1,384,086	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	692,526		692,526	0	692,526	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,104,553		1,104,553	0	1,104,553	59.00
60.00	06000	LABORATORY	4,886,981		4,886,981	0	4,886,981	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	905,535		905,535	0	905,535	62.00
65.00	06500	RESPIRATORY THERAPY	1,986,505	0	1,986,505	0	1,986,505	65.00
66.00	06600	PHYSICAL THERAPY	2,104,304	0	2,104,304	21,066	2,125,370	66.00
69.00	06900	ELECTROCARDIOLOGY	1,578,836		1,578,836	11,559	1,590,395	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	139,105		139,105	0	139,105	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,771,423		9,771,423	0	9,771,423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,380,130		8,380,130	0	8,380,130	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,427,200		17,427,200	0	17,427,200	73.00
74.00	07400	RENAL DIALYSIS	780,924		780,924	0	780,924	74.00
76.00	03950	LITHOTRIPSY	311,899		311,899	0	311,899	76.00
76.01	03330	ENDOSCOPY	1,961,999		1,961,999	19,569	1,981,568	76.01
76.02	03040	PRISION CLINIC	547,040		547,040	0	547,040	76.02
76.03	03050	WOUND CARE	1,010,725		1,010,725	11,596	1,022,321	76.03
76.04	03060	OPIC	1,198,398		1,198,398	25,595	1,223,993	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,805,929		5,805,929	32,630	5,838,559	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,868,045		1,868,045		1,868,045	92.00
200.00		Subtotal (see instructions)	116,123,982	0	116,123,982	149,917	116,273,899	200.00
201.00		Less Observation Beds	1,868,045		1,868,045		1,868,045	201.00
202.00		Total (see instructions)	114,255,937	0	114,255,937	149,917	114,405,854	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,487,222		20,487,222			30.00
31.00	03100	INTENSIVE CARE UNIT	10,170,730		10,170,730			31.00
40.00	04000	SUBPROVIDER - IPF	25,931,452		25,931,452			40.00
41.00	04100	SUBPROVIDER - IRF	2,810,229		2,810,229			41.00
43.00	04300	NURSERY	2,023,695		2,023,695			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	53,564,008	54,534,042	108,098,050	0.094052	0.000000	50.00
51.00	05100	RECOVERY ROOM	5,640,970	8,705,047	14,346,017	0.077120	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,466,522	295,232	4,761,754	0.445780	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,605,323	10,164,530	14,769,853	0.246485	0.000000	54.00
54.01	03630	ULTRA SOUND	1,320,056	3,844,024	5,164,080	0.079672	0.000000	54.01
54.02	03440	MAMMOGRAPHY	3,390	1,984,137	1,987,527	0.267403	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	884,598	15,379,595	16,264,193	0.111551	0.000000	55.00
56.00	05600	RADIOISOTOPE	1,099,026	11,292,077	12,391,103	0.094887	0.000000	56.00
57.00	05700	CT SCAN	18,327,303	37,738,524	56,065,827	0.024687	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,781,637	8,893,157	12,674,794	0.054638	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,008,804	12,749,130	25,757,934	0.042882	0.000000	59.00
60.00	06000	LABORATORY	33,076,895	40,917,323	73,994,218	0.066045	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,939,004	1,266,671	6,205,675	0.145920	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	16,944,931	1,139,005	18,083,936	0.109849	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,740,674	265,805	7,006,479	0.300337	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	10,960,713	8,784,551	19,745,264	0.079960	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	550,549	826,084	1,376,633	0.101047	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,142,049	20,357,892	49,499,941	0.197403	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,956,821	12,423,360	26,380,181	0.317668	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,450,818	51,213,066	116,663,884	0.149380	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,178,788	90,925	4,269,713	0.182898	0.000000	74.00
76.00	03950	LITHOTRIPSY	60,830	3,201,844	3,262,674	0.095596	0.000000	76.00
76.01	03330	ENDOSCOPY	3,540,340	34,438,545	37,978,885	0.051660	0.000000	76.01
76.02	03040	PRISION CLINIC	3,291	592,769	596,060	0.917760	0.000000	76.02
76.03	03050	WOUND CARE	43,823	2,376,101	2,419,924	0.417668	0.000000	76.03
76.04	03060	OPIC	28,272	5,983,214	6,011,486	0.199351	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	19,975,229	45,309,528	65,284,757	0.088932	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	410,068	1,515,527	1,925,595	0.970113	0.000000	92.00
200.00		Subtotal (see instructions)	378,128,060	396,281,705	774,409,765			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	378,128,060	396,281,705	774,409,765			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03950	LITHOTRIPSY	0.000000	76.00
76.01	03330	ENDOSCOPY	0.000000	76.01
76.02	03040	PRISION CLINIC	0.000000	76.02
76.03	03050	WOUND CARE	0.000000	76.03
76.04	03060	OPIC	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part I Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,194,912	0	2,194,912	18,309	119.88	30.00
31.00	INTENSIVE CARE UNIT	485,437		485,437	3,295	147.33	31.00
40.00	SUBPROVIDER - IPF	463,237	0	463,237	6,598	70.21	40.00
41.00	SUBPROVIDER - IRF	351,053	0	351,053	2,094	167.65	41.00
43.00	NURSERY	86,878		86,878	979	88.74	43.00
200.00	Total (lines 30 through 199)	3,581,517		3,581,517	31,275		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	8,853	1,061,298	30.00
31.00	INTENSIVE CARE UNIT	1,593	234,697	31.00
40.00	SUBPROVIDER - IPF	1,424	99,979	40.00
41.00	SUBPROVIDER - IRF	1,264	211,910	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	13,134	1,607,884	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part II Date/Time Prepared: 1/30/2019 11:15 am
	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	1,062,038	108,098,050	0.009825	23,690,168	232,756	50.00
51.00	05100	RECOVERY ROOM	73,949	14,346,017	0.005155	2,666,370	13,745	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,018	4,761,754	0.039065	8,608	336	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	534,513	14,769,853	0.036189	2,311,943	83,667	54.00
54.01	03630	ULTRA SOUND	51,031	5,164,080	0.009882	613,248	6,060	54.01
54.02	03440	MAMMOGRAPHY	103,319	1,987,527	0.051984	881	46	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	164,937	16,264,193	0.010141	417,092	4,230	55.00
56.00	05600	RADIOISOTOPE	58,944	12,391,103	0.004757	586,384	2,789	56.00
57.00	05700	CT SCAN	89,361	56,065,827	0.001594	9,090,967	14,491	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	68,337	12,674,794	0.005392	1,928,138	10,397	58.00
59.00	05900	CARDIAC CATHETERIZATION	92,792	25,757,934	0.003602	6,239,513	22,475	59.00
60.00	06000	LABORATORY	319,615	73,994,218	0.004319	16,306,807	70,429	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,728	6,205,675	0.005113	2,564,961	13,115	62.00
65.00	06500	RESPIRATORY THERAPY	105,286	18,083,936	0.005822	9,426,224	54,879	65.00
66.00	06600	PHYSICAL THERAPY	250,011	7,006,479	0.035683	1,873,642	66,857	66.00
69.00	06900	ELECTROCARDIOLOGY	158,002	19,745,264	0.008002	6,184,266	49,486	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,873	1,376,633	0.012983	349,173	4,533	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	424,236	49,499,941	0.008570	14,000,839	119,987	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	215,905	26,380,181	0.008184	6,611,240	54,106	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	574,928	116,663,884	0.004928	30,181,065	148,732	73.00
74.00	07400	RENAL DIALYSIS	46,290	4,269,713	0.010841	2,870,996	31,124	74.00
76.00	03950	LITHOTRIPSY	8,136	3,262,674	0.002494	0	0	76.00
76.01	03330	ENDOSCOPY	98,456	37,978,885	0.002592	2,094,405	5,429	76.01
76.02	03040	PRISION CLINIC	131,435	596,060	0.220506	0	0	76.02
76.03	03050	WOUND CARE	93,750	2,419,924	0.038741	26,477	1,026	76.03
76.04	03060	OPIC	150,355	6,011,486	0.025011	16,303	408	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	532,586	65,284,757	0.008158	8,532,498	69,608	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	229,454	1,925,595	0.119160	201,372	23,995	92.00
200.00		Total (lines 50 through 199)	5,873,285	712,986,437		148,793,580	1,104,706	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part III Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	18,309	0.00	8,853	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,295	0.00	1,593	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	6,598	0.00	1,424	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	2,094	0.00	1,264	41.00
43.00	04300	NURSERY		0	979	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	31,275		13,134	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/30/2019 11:15 am

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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO 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	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	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: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	108,098,050	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,346,017	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,761,754	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,769,853	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	5,164,080	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	1,987,527	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	16,264,193	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	12,391,103	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	56,065,827	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,674,794	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	25,757,934	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	73,994,218	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6,205,675	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,083,936	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,006,479	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,745,264	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,376,633	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49,499,941	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	26,380,181	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	116,663,884	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,269,713	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	3,262,674	0.000000	76.00
76.01	03330	ENDOSCOPY	0	0	0	37,978,885	0.000000	76.01
76.02	03040	PRISION CLINIC	0	0	0	596,060	0.000000	76.02
76.03	03050	WOUND CARE	0	0	0	2,419,924	0.000000	76.03
76.04	03060	OPIC	0	0	0	6,011,486	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	65,284,757	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,925,595	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	712,986,437		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046

Period: From 09/01/2017 To 08/31/2018

Worksheet D Part IV

Date/Time Prepared: 1/30/2019 11:15 am

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	23,690,168	0	16,373,870	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	2,666,370	0	2,485,243	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	8,608	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,311,943	0	2,493,929	0	54.00
54.01	03630	ULTRA SOUND	0.000000	613,248	0	935,391	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	881	0	160,552	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	417,092	0	8,546,498	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	586,384	0	5,285,160	0	56.00
57.00	05700	CT SCAN	0.000000	9,090,967	0	11,266,585	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	1,928,138	0	2,478,057	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	6,239,513	0	6,714,804	0	59.00
60.00	06000	LABORATORY	0.000000	16,306,807	0	9,065,653	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	2,564,961	0	589,067	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	9,426,224	0	213,022	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,873,642	0	39,931	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	6,184,266	0	3,390,457	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	349,173	0	260,046	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	14,000,839	0	7,539,329	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,611,240	0	5,059,057	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	30,181,065	0	19,461,715	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	2,870,996	0	90,925	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	879,263	0	76.00
76.01	03330	ENDOSCOPY	0.000000	2,094,405	0	14,006,015	0	76.01
76.02	03040	PRISION CLINIC	0.000000	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.000000	26,477	0	1,119,610	0	76.03
76.04	03060	OPIC	0.000000	16,303	0	2,671,577	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	8,532,498	0	8,448,159	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	201,372	0	278,593	0	92.00
200.00		Total (lines 50 through 199)		148,793,580	0	129,852,508	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part V Date/Time Prepared: 1/30/2019 11:15 am

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	0.094052	16,373,870	0	0	1,539,995	50.00
51.00	05100	RECOVERY ROOM	0.077120	2,485,243	0	0	191,662	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.445780	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246485	2,493,929	0	0	614,716	54.00
54.01	03630	ULTRA SOUND	0.079672	935,391	0	0	74,524	54.01
54.02	03440	MAMMOGRAPHY	0.267403	160,552	0	0	42,932	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.111551	8,546,498	0	0	953,370	55.00
56.00	05600	RADIOISOTOPE	0.094887	5,285,160	0	0	501,493	56.00
57.00	05700	CT SCAN	0.024687	11,266,585	0	0	278,138	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.054638	2,478,057	0	0	135,396	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.042882	6,714,804	0	0	287,944	59.00
60.00	06000	LABORATORY	0.066045	9,065,653	0	0	598,741	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.145920	589,067	0	0	85,957	62.00
65.00	06500	RESPIRATORY THERAPY	0.109849	213,022	0	0	23,400	65.00
66.00	06600	PHYSICAL THERAPY	0.300337	39,931	0	0	11,993	66.00
69.00	06900	ELECTROCARDIOLOGY	0.079960	3,390,457	0	0	271,101	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.101047	260,046	0	0	26,277	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.197403	7,539,329	0	0	1,488,286	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317668	5,059,057	0	0	1,607,101	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.149380	19,461,715	0	73,176	2,907,191	73.00
74.00	07400	RENAL DIALYSIS	0.182898	90,925	0	0	16,630	74.00
76.00	03950	LITHOTRIPSY	0.095596	879,263	0	0	84,054	76.00
76.01	03330	ENDOSCOPY	0.051660	14,006,015	0	0	723,551	76.01
76.02	03040	PRISION CLINIC	0.917760	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.417668	1,119,610	0	0	467,625	76.03
76.04	03060	OPIC	0.199351	2,671,577	0	0	532,582	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.088932	8,448,159	0	0	751,312	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.970113	278,593	0	0	270,267	92.00
200.00		Subtotal (see instructions)		129,852,508	0	73,176	14,486,238	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		129,852,508	0	73,176	14,486,238	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part V Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,931	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	76.02
76.03	03050	WOUND CARE	0	0	76.03
76.04	03060	OPIC	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS			
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	10,931	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	10,931	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part II | Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,062,038	108,098,050	0.009825	1,916	19	50.00
51.00	05100	RECOVERY ROOM	73,949	14,346,017	0.005155	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,018	4,761,754	0.039065	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	534,513	14,769,853	0.036189	15,572	564	54.00
54.01	03630	ULTRA SOUND	51,031	5,164,080	0.009882	1,282	13	54.01
54.02	03440	MAMMOGRAPHY	103,319	1,987,527	0.051984	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	164,937	16,264,193	0.010141	0	0	55.00
56.00	05600	RADIOISOTOPE	58,944	12,391,103	0.004757	4,610	22	56.00
57.00	05700	CT SCAN	89,361	56,065,827	0.001594	49,771	79	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	68,337	12,674,794	0.005392	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	92,792	25,757,934	0.003602	22,323	80	59.00
60.00	06000	LABORATORY	319,615	73,994,218	0.004319	440,755	1,904	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,728	6,205,675	0.005113	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	105,286	18,083,936	0.005822	96,431	561	65.00
66.00	06600	PHYSICAL THERAPY	250,011	7,006,479	0.035683	15,038	537	66.00
69.00	06900	ELECTROCARDIOLOGY	158,002	19,745,264	0.008002	70,901	567	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,873	1,376,633	0.012983	3,108	40	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	424,236	49,499,941	0.008570	14,319	123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	215,905	26,380,181	0.008184	5,738	47	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	574,928	116,663,884	0.004928	639,307	3,151	73.00
74.00	07400	RENAL DIALYSIS	46,290	4,269,713	0.010841	10,866	118	74.00
76.00	03950	LITHOTRIPSY	8,136	3,262,674	0.002494	0	0	76.00
76.01	03330	ENDOSCOPY	98,456	37,978,885	0.002592	0	0	76.01
76.02	03040	PRISION CLINIC	131,435	596,060	0.220506	0	0	76.02
76.03	03050	WOUND CARE	93,750	2,419,924	0.038741	425	16	76.03
76.04	03060	OPIC	150,355	6,011,486	0.025011	1,667	42	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	532,586	65,284,757	0.008158	428,639	3,497	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,925,595	0.000000	2,752	0	92.00
200.00		Total (lines 50 through 199)	5,643,831	712,986,437		1,825,420	11,380	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part IV Date/Time Prepared: 1/30/2019 11:15 am
	Title XVIII	Subprovider - IPF	PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO 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	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	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: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	108,098,050	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,346,017	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,761,754	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,769,853	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	5,164,080	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	1,987,527	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	16,264,193	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	12,391,103	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	56,065,827	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,674,794	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	25,757,934	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	73,994,218	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6,205,675	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,083,936	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,006,479	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,745,264	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,376,633	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49,499,941	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	26,380,181	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	116,663,884	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,269,713	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	3,262,674	0.000000	76.00
76.01	03330	ENDOSCOPY	0	0	0	37,978,885	0.000000	76.01
76.02	03040	PRISION CLINIC	0	0	0	596,060	0.000000	76.02
76.03	03050	WOUND CARE	0	0	0	2,419,924	0.000000	76.03
76.04	03060	OPIC	0	0	0	6,011,486	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	65,284,757	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,925,595	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	712,986,437		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,916	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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	15,572	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	1,282	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	4,610	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	49,771	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	22,323	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	440,755	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	96,431	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	15,038	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	70,901	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	3,108	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	14,319	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,738	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	639,307	0	5,968	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	10,866	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.000000	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0.000000	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.000000	425	0	0	0	76.03
76.04	03060	OPIC	0.000000	1,667	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	428,639	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,752	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,825,420	0	5,968	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part V | Date/Time Prepared: 1/30/2019 11:15 am

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	0.094052	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.077120	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.445780	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246485	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.079672	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.267403	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.111551	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.094887	0	0	0	0	56.00
57.00	05700	CT SCAN	0.024687	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.054638	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.042882	0	0	0	0	59.00
60.00	06000	LABORATORY	0.066045	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.145920	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.109849	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.300337	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.079960	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.101047	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.197403	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317668	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.149380	5,968	0	7,588	891	73.00
74.00	07400	RENAL DIALYSIS	0.182898	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.095596	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.051660	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0.917760	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.417668	0	0	0	0	76.03
76.04	03060	OPIC	0.199351	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.088932	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.970113	0	0	0	0	92.00
200.00		Subtotal (see instructions)		5,968	0	7,588	891	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		5,968	0	7,588	891	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part V | Date/Time Prepared: 1/30/2019 11:15 am

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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,133	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	76.02
76.03	03050	WOUND CARE	0	0	76.03
76.04	03060	OPIC	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS			
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	1,133	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	1,133	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part II | Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,062,038	108,098,050	0.009825	96,739	950	50.00
51.00	05100	RECOVERY ROOM	73,949	14,346,017	0.005155	18,294	94	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,018	4,761,754	0.039065	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	534,513	14,769,853	0.036189	50,421	1,825	54.00
54.01	03630	ULTRA SOUND	51,031	5,164,080	0.009882	7,075	70	54.01
54.02	03440	MAMMOGRAPHY	103,319	1,987,527	0.051984	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	164,937	16,264,193	0.010141	3,700	38	55.00
56.00	05600	RADIOISOTOPE	58,944	12,391,103	0.004757	14,640	70	56.00
57.00	05700	CT SCAN	89,361	56,065,827	0.001594	54,237	86	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	68,337	12,674,794	0.005392	31,487	170	58.00
59.00	05900	CARDIAC CATHETERIZATION	92,792	25,757,934	0.003602	0	0	59.00
60.00	06000	LABORATORY	319,615	73,994,218	0.004319	340,534	1,471	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,728	6,205,675	0.005113	42,649	218	62.00
65.00	06500	RESPIRATORY THERAPY	105,286	18,083,936	0.005822	62,842	366	65.00
66.00	06600	PHYSICAL THERAPY	250,011	7,006,479	0.035683	2,158,963	77,038	66.00
69.00	06900	ELECTROCARDIOLOGY	158,002	19,745,264	0.008002	36,156	289	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,873	1,376,633	0.012983	6,215	81	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	424,236	49,499,941	0.008570	219,035	1,877	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	215,905	26,380,181	0.008184	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	574,928	116,663,884	0.004928	1,062,670	5,237	73.00
74.00	07400	RENAL DIALYSIS	46,290	4,269,713	0.010841	92,361	1,001	74.00
76.00	03950	LITHOTRIPSY	8,136	3,262,674	0.002494	0	0	76.00
76.01	03330	ENDOSCOPY	98,456	37,978,885	0.002592	0	0	76.01
76.02	03040	PRISION CLINIC	131,435	596,060	0.220506	0	0	76.02
76.03	03050	WOUND CARE	93,750	2,419,924	0.038741	0	0	76.03
76.04	03060	OPIC	150,355	6,011,486	0.025011	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	532,586	65,284,757	0.008158	6,959	57	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,925,595	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	5,643,831	712,986,437		4,304,977	90,938	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO 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	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	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: 15-0046 Component CCN: 15-T046	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part IV Date/Time Prepared: 1/30/2019 11:15 am
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	108,098,050	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,346,017	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,761,754	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,769,853	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	5,164,080	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	1,987,527	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	16,264,193	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	12,391,103	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	56,065,827	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,674,794	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	25,757,934	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	73,994,218	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6,205,675	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,083,936	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,006,479	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,745,264	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,376,633	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49,499,941	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	26,380,181	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	116,663,884	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,269,713	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	3,262,674	0.000000	76.00
76.01	03330	ENDOSCOPY	0	0	0	37,978,885	0.000000	76.01
76.02	03040	PRISION CLINIC	0	0	0	596,060	0.000000	76.02
76.03	03050	WOUND CARE	0	0	0	2,419,924	0.000000	76.03
76.04	03060	OPIC	0	0	0	6,011,486	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	65,284,757	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,925,595	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	712,986,437		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-T046

Period: From 09/01/2017 To 08/31/2018

Worksheet D Part IV | Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	96,739	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	18,294	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	50,421	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	7,075	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	3,700	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	14,640	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	54,237	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	31,487	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	340,534	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	42,649	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	62,842	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,158,963	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	36,156	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	6,215	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	219,035	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	1,062,670	0	2,226	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	92,361	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.000000	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0.000000	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.000000	0	0	401	0	76.03
76.04	03060	OPIC	0.000000	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	6,959	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)		4,304,977	0	2,627	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part V | Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.094052	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.077120	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.445780	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246485	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.079672	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.267403	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.111551	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.094887	0	0	0	0	56.00
57.00	05700	CT SCAN	0.024687	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.054638	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.042882	0	0	0	0	59.00
60.00	06000	LABORATORY	0.066045	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.145920	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.109849	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.300337	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.079960	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.101047	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.197403	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317668	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.149380	2,226	0	2,741	333	73.00
74.00	07400	RENAL DIALYSIS	0.182898	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.095596	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.051660	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0.917760	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.417668	401	0	0	167	76.03
76.04	03060	OPIC	0.199351	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.088932	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.970113	0	0	0	0	92.00
200.00		Subtotal (see instructions)		2,627	0	2,741	500	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		2,627	0	2,741	500	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part V | Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	409	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	76.02
76.03	03050	WOUND CARE	0	0	76.03
76.04	03060	OPIC	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS			
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	409	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	409	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part III Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	18,309	0.00	968	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,295	0.00	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	6,598	0.00	2,875	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	2,094	0.00	103	41.00
43.00	04300	NURSERY		0	979	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	31,275		3,946	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046

Period: From 09/01/2017 To 08/31/2018

Worksheet D Part IV
Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Hospital | Cost

		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO 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	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	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: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	108,098,050	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,346,017	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,761,754	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,769,853	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	5,164,080	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	1,987,527	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	16,264,193	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	12,391,103	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	56,065,827	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,674,794	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	25,757,934	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	73,994,218	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6,205,675	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,083,936	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,006,479	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,745,264	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,376,633	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49,499,941	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	26,380,181	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	116,663,884	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,269,713	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	3,262,674	0.000000	76.00
76.01	03330	ENDOSCOPY	0	0	0	37,978,885	0.000000	76.01
76.02	03040	PRISION CLINIC	0	0	0	596,060	0.000000	76.02
76.03	03050	WOUND CARE	0	0	0	2,419,924	0.000000	76.03
76.04	03060	OPIC	0	0	0	6,011,486	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	65,284,757	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,925,595	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	712,986,437		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Hospital | Cost

		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	6,495,797	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	709,121	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	2,809,631	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	581,455	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	279,637	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	103,401	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	155,103	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	2,093,224	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	489,432	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,383,339	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	4,428,796	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	672,121	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,759,715	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	317,624	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,239,973	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	77,194	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,663,045	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,545,352	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	9,258,192	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	413,501	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.000000	371,080	0	0	0	76.01
76.02	03040	PRISION CLINIC	0.000000	1,616	0	0	0	76.02
76.03	03050	WOUND CARE	0.000000	7,300	0	0	0	76.03
76.04	03060	OPIC	0.000000	293	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	2,316,474	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	84,518	0	0	0	92.00
200.00		Total (lines 50 through 199)		41,256,934	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part V Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Hospital | Cost

		Cost Center Description		Charges			Costs	
			Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.094052	0	0	11,148,970	0	50.00
51.00	05100	RECOVERY ROOM	0.077120	0	0	1,773,321	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.445780	0	0	138,003	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246485	0	0	2,478,284	0	54.00
54.01	03630	ULTRA SOUND	0.079672	0	0	989,872	0	54.01
54.02	03440	MAMMOGRAPHY	0.267403	0	0	183,338	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.111551	0	0	1,247,199	0	55.00
56.00	05600	RADIOISOTOPE	0.094887	0	0	1,064,407	0	56.00
57.00	05700	CT SCAN	0.024687	0	0	7,894,920	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.054638	0	0	1,329,755	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.042882	0	0	1,176,251	0	59.00
60.00	06000	LABORATORY	0.066045	0	0	9,691,501	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.145920	0	0	140,886	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.109849	0	0	394,506	0	65.00
66.00	06600	PHYSICAL THERAPY	0.300337	0	0	35,012	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.079960	0	0	1,338,285	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.101047	0	0	242,585	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.197403	0	0	3,116,487	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317668	0	0	2,225,286	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.149380	0	0	8,013,936	0	73.00
74.00	07400	RENAL DIALYSIS	0.182898	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.095596	0	0	486,636	0	76.00
76.01	03330	ENDOSCOPY	0.051660	0	0	4,072,768	0	76.01
76.02	03040	PRISION CLINIC	0.917760	0	0	712	0	76.02
76.03	03050	WOUND CARE	0.417668	0	0	309,627	0	76.03
76.04	03060	OPIC	0.199351	0	0	658,101	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.088932	0	0	15,090,962	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.970113	0	0	533,393	0	92.00
200.00		Subtotal (see instructions)		0	0	75,775,003	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	75,775,003	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part V Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	1,048,583	50.00
51.00	05100	RECOVERY ROOM	0	136,759	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	61,519	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	610,860	54.00
54.01	03630	ULTRA SOUND	0	78,865	54.01
54.02	03440	MAMMOGRAPHY	0	49,025	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	139,126	55.00
56.00	05600	RADIOISOTOPE	0	100,998	56.00
57.00	05700	CT SCAN	0	194,902	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	72,655	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	50,440	59.00
60.00	06000	LABORATORY	0	640,075	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	20,558	62.00
65.00	06500	RESPIRATORY THERAPY	0	43,336	65.00
66.00	06600	PHYSICAL THERAPY	0	10,515	66.00
69.00	06900	ELECTROCARDIOLOGY	0	107,009	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	24,512	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	615,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	706,902	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,197,122	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	LITHOTRIPSY	0	46,520	76.00
76.01	03330	ENDOSCOPY	0	210,399	76.01
76.02	03040	PRISION CLINIC	0	653	76.02
76.03	03050	WOUND CARE	0	129,321	76.03
76.04	03060	OPIC	0	131,193	76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	1,342,069	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	517,451	92.00
200.00		Subtotal (see instructions)	0	8,286,571	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	8,286,571	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Subprovider - IPF | Cost

		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO 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	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	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: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	108,098,050	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,346,017	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,761,754	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,769,853	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	5,164,080	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	1,987,527	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	16,264,193	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	12,391,103	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	56,065,827	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,674,794	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	25,757,934	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	73,994,218	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6,205,675	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,083,936	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,006,479	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,745,264	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,376,633	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49,499,941	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	26,380,181	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	116,663,884	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,269,713	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	3,262,674	0.000000	76.00
76.01	03330	ENDOSCOPY	0	0	0	37,978,885	0.000000	76.01
76.02	03040	PRISION CLINIC	0	0	0	596,060	0.000000	76.02
76.03	03050	WOUND CARE	0	0	0	2,419,924	0.000000	76.03
76.04	03060	OPIC	0	0	0	6,011,486	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	65,284,757	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,925,595	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	712,986,437		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Subprovider - IPF | Cost

		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	533	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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	35,192	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	13,683	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	4,147	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	108,107	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	14,303	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	967,247	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	3,594	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	113,957	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	14,579	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	64,299	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	3,356	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	15,105	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	1,003,920	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.000000	5,400	0	0	0	76.01
76.02	03040	PRISION CLINIC	0.000000	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.000000	0	0	0	0	76.03
76.04	03060	OPIC	0.000000	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	1,093,971	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	5,136	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,466,529	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-T046

Period: From 09/01/2017 To 08/31/2018

Worksheet D Part IV | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Subprovider - IRF | Cost

		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO 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	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	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: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	108,098,050	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,346,017	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,761,754	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,769,853	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	5,164,080	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	1,987,527	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	16,264,193	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	12,391,103	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	56,065,827	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,674,794	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	25,757,934	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	73,994,218	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6,205,675	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,083,936	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,006,479	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,745,264	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,376,633	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49,499,941	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	26,380,181	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	116,663,884	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,269,713	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	3,262,674	0.000000	76.00
76.01	03330	ENDOSCOPY	0	0	0	37,978,885	0.000000	76.01
76.02	03040	PRISION CLINIC	0	0	0	596,060	0.000000	76.02
76.03	03050	WOUND CARE	0	0	0	2,419,924	0.000000	76.03
76.04	03060	OPIC	0	0	0	6,011,486	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	65,284,757	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,925,595	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	712,986,437		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Subprovider - IRF | Cost

		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	231,782	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	7,427	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	14,032	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	1,347	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	24,954	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	37,677	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	96,549	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	38,631	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	44,922	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	301,231	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	11,196	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71,174	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	47,198	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	309,409	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	59,763	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.000000	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0.000000	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.000000	0	0	0	0	76.03
76.04	03060	OPIC	0.000000	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	31,761	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)		1,329,053	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/30/2019 11:15 am

	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)	18,309	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	18,309	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)	16,395	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)	8,853	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)	17,869,405	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)	17,869,405	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)	17,869,405	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)	975.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,640,439	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)	8,640,439	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,175,430	3,295	1,570.69	1,593	2,502,109	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	18,324,338	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	29,466,886	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,295,995	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,104,706	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,400,701	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	27,066,185	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)	1,914	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	975.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,868,045	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,194,912	17,869,405	0.122831	1,868,045	229,454	90.00
91.00	Nursing School cost	0	17,869,405	0.000000	1,868,045	0	91.00
92.00	Allied health cost	0	17,869,405	0.000000	1,868,045	0	92.00
93.00	All other Medical Education	0	17,869,405	0.000000	1,868,045	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,598	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,598	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)	6,598	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,424	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)	4,924,028	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)	4,924,028	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)	4,924,028	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)	746.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,062,717	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,062,717	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	200,693	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,263,410	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)	99,979	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	11,380	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	111,359	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,152,051	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: 15-0046 Component CCN: 15-S046	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Prepared: 1/30/2019 11:15 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	463,237	4,924,028	0.094077	0	0	90.00
91.00	Nursing School cost	0	4,924,028	0.000000	0	0	91.00
92.00	Allied health cost	0	4,924,028	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,924,028	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Prepared: 1/30/2019 11:15 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,094	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,094	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,094	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,264	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)	2,519,565	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)	2,519,565	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)	2,519,565	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,203.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,520,883	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,520,883	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description	1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	941,923	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,462,806	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)	211,910	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	90,938	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	302,848	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,159,958	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: 15-0046 Component CCN: 15-T046	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Prepared: 1/30/2019 11:15 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	351,053	2,519,565	0.139331	0	0	90.00
91.00	Nursing School cost	0	2,519,565	0.000000	0	0	91.00
92.00	Allied health cost	0	2,519,565	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,519,565	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	18,309	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	18,309	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)	16,395	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)	968	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)	979	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)	17,869,405	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)	17,869,405	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)	17,869,405	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)	975.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	944,758	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)	944,758	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	819,987	979	837.58	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,175,430	3,295	1,570.69	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	5,930,745	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,875,503	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,914	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	975.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,868,045	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Prepared: 1/30/2019 11:15 am
	Title XIX	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,194,912	17,869,405	0.122831	1,868,045	229,454	90.00
91.00	Nursing School cost	0	17,869,405	0.000000	1,868,045	0	91.00
92.00	Allied health cost	0	17,869,405	0.000000	1,868,045	0	92.00
93.00	All other Medical Education	0	17,869,405	0.000000	1,868,045	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,598	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,598	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)	6,598	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)	2,875	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)	979	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)	4,924,028	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)	4,924,028	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)	4,924,028	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)	746.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,145,584	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)	2,145,584	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1

Component CCN: 15-S046 | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Subprovider - IPF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	355,939	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,501,523	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Prepared: 1/30/2019 11:15 am
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	463,237	4,924,028	0.094077	0	0	90.00
91.00	Nursing School cost	0	4,924,028	0.000000	0	0	91.00
92.00	Allied health cost	0	4,924,028	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,924,028	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,094	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,094	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,094	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)	103	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)	979	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)	2,519,565	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)	2,519,565	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)	2,519,565	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,203.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	123,933	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)	123,933	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1
Component CCN: 15-T046 | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Subprovider - IRF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	226,987	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	350,920	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1
Component CCN: 15-T046 | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	351,053	2,519,565	0.139331	0	0	90.00
91.00	Nursing School cost	0	2,519,565	0.000000	0	0	91.00
92.00	Allied health cost	0	2,519,565	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,519,565	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-3 | Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,619,386		30.00
31.00	03100	INTENSIVE CARE UNIT		4,822,956		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.094055	23,690,168	2,228,179	50.00
51.00	05100	RECOVERY ROOM	0.077120	2,666,370	205,630	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.445780	8,608	3,837	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246485	2,311,943	569,859	54.00
54.01	03630	ULTRA SOUND	0.079672	613,248	48,859	54.01
54.02	03440	MAMMOGRAPHY	0.267403	881	236	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.111551	417,092	46,527	55.00
56.00	05600	RADIOISOTOPE	0.094887	586,384	55,640	56.00
57.00	05700	CT SCAN	0.024687	9,090,967	224,429	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.054638	1,928,138	105,350	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.042882	6,239,513	267,563	59.00
60.00	06000	LABORATORY	0.066045	16,306,807	1,076,983	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.145920	2,564,961	374,279	62.00
65.00	06500	RESPIRATORY THERAPY	0.109849	9,426,224	1,035,461	65.00
66.00	06600	PHYSICAL THERAPY	0.303344	1,873,642	568,358	66.00
69.00	06900	ELECTROCARDIOLOGY	0.080546	6,184,266	498,118	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.101047	349,173	35,283	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.197403	14,000,839	2,763,808	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317668	6,611,240	2,100,179	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.149380	30,181,065	4,508,447	73.00
74.00	07400	RENAL DIALYSIS	0.182898	2,870,996	525,099	74.00
76.00	03950	LITHOTRIPSY	0.095596	0	0	76.00
76.01	03330	ENDOSCOPY	0.052176	2,094,405	109,278	76.01
76.02	03040	PRISION CLINIC	0.917760	0	0	76.02
76.03	03050	WOUND CARE	0.422460	26,477	11,185	76.03
76.04	03060	OPIC	0.203609	16,303	3,319	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.089432	8,532,498	763,078	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.970113	201,372	195,354	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		148,793,580	18,324,338	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)		148,793,580		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-3 | Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		5,577,050		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.094055	1,916	180	50.00
51.00	05100	RECOVERY ROOM	0.077120	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.445780	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246485	15,572	3,838	54.00
54.01	03630	ULTRA SOUND	0.079672	1,282	102	54.01
54.02	03440	MAMMOGRAPHY	0.267403	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.111551	0	0	55.00
56.00	05600	RADIOISOTOPE	0.094887	4,610	437	56.00
57.00	05700	CT SCAN	0.024687	49,771	1,229	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.054638	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.042882	22,323	957	59.00
60.00	06000	LABORATORY	0.066045	440,755	29,110	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.145920	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.109849	96,431	10,593	65.00
66.00	06600	PHYSICAL THERAPY	0.303344	15,038	4,562	66.00
69.00	06900	ELECTROCARDIOLOGY	0.080546	70,901	5,711	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.101047	3,108	314	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.197403	14,319	2,827	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317668	5,738	1,823	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.149380	639,307	95,500	73.00
74.00	07400	RENAL DIALYSIS	0.182898	10,866	1,987	74.00
76.00	03950	LITHOTRIPSY	0.095596	0	0	76.00
76.01	03330	ENDOSCOPY	0.052176	0	0	76.01
76.02	03040	PRISION CLINIC	0.917760	0	0	76.02
76.03	03050	WOUND CARE	0.422460	425	180	76.03
76.04	03060	OPIC	0.203609	1,667	339	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.089432	428,639	38,334	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.970113	2,752	2,670	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,825,420	200,693	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,825,420		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2017 To 08/31/2018	Worksheet D-3 Date/Time Prepared: 1/30/2019 11:15 am
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		1,684,077		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.094055	96,739	9,099	50.00
51.00	05100	RECOVERY ROOM	0.077120	18,294	1,411	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.445780	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246485	50,421	12,428	54.00
54.01	03630	ULTRA SOUND	0.079672	7,075	564	54.01
54.02	03440	MAMMOGRAPHY	0.267403	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.111551	3,700	413	55.00
56.00	05600	RADIOISOTOPE	0.094887	14,640	1,389	56.00
57.00	05700	CT SCAN	0.024687	54,237	1,339	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.054638	31,487	1,720	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.042882	0	0	59.00
60.00	06000	LABORATORY	0.066045	340,534	22,491	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.145920	42,649	6,223	62.00
65.00	06500	RESPIRATORY THERAPY	0.109849	62,842	6,903	65.00
66.00	06600	PHYSICAL THERAPY	0.303344	2,158,963	654,908	66.00
69.00	06900	ELECTROCARDIOLOGY	0.080546	36,156	2,912	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.101047	6,215	628	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.197403	219,035	43,238	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317668	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.149380	1,062,670	158,742	73.00
74.00	07400	RENAL DIALYSIS	0.182898	92,361	16,893	74.00
76.00	03950	LITHOTRIPSY	0.095596	0	0	76.00
76.01	03330	ENDOSCOPY	0.052176	0	0	76.01
76.02	03040	PRISION CLINIC	0.917760	0	0	76.02
76.03	03050	WOUND CARE	0.422460	0	0	76.03
76.04	03060	OPIC	0.203609	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.089432	6,959	622	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.970113	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,304,977	941,923	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,304,977		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-3 | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,984,198		30.00
31.00	03100	INTENSIVE CARE UNIT		1,361,302		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		1,373,909		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.094052	6,495,797	610,943	50.00
51.00	05100	RECOVERY ROOM	0.077120	709,121	54,687	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.445780	2,809,631	1,252,477	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246485	581,455	143,320	54.00
54.01	03630	ULTRA SOUND	0.079672	279,637	22,279	54.01
54.02	03440	MAMMOGRAPHY	0.267403	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.111551	103,401	11,534	55.00
56.00	05600	RADIOISOTOPE	0.094887	155,103	14,717	56.00
57.00	05700	CT SCAN	0.024687	2,093,224	51,675	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.054638	489,432	26,742	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.042882	1,383,339	59,320	59.00
60.00	06000	LABORATORY	0.066045	4,428,796	292,500	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.145920	672,121	98,076	62.00
65.00	06500	RESPIRATORY THERAPY	0.109849	2,759,715	303,152	65.00
66.00	06600	PHYSICAL THERAPY	0.300337	317,624	95,394	66.00
69.00	06900	ELECTROCARDIOLOGY	0.079960	1,239,973	99,148	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.101047	77,194	7,800	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.197403	2,663,045	525,693	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317668	1,545,352	490,909	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.149380	9,258,192	1,382,989	73.00
74.00	07400	RENAL DIALYSIS	0.182898	413,501	75,629	74.00
76.00	03950	LITHOTRIPSY	0.095596	0	0	76.00
76.01	03330	ENDOSCOPY	0.051660	371,080	19,170	76.01
76.02	03040	PRISION CLINIC	0.917760	1,616	1,483	76.02
76.03	03050	WOUND CARE	0.417668	7,300	3,049	76.03
76.04	03060	OPIC	0.199351	293	58	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.088932	2,316,474	206,009	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.970113	84,518	81,992	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		41,256,934	5,930,745	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)		41,256,934		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2017 To 08/31/2018	Worksheet D-3 Date/Time Prepared: 1/30/2019 11:15 am
	Title XIX	Subprovider - IPF	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		9,682,394		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.094052	533	50	50.00
51.00	05100	RECOVERY ROOM	0.077120	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.445780	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246485	35,192	8,674	54.00
54.01	03630	ULTRA SOUND	0.079672	13,683	1,090	54.01
54.02	03440	MAMMOGRAPHY	0.267403	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.111551	0	0	55.00
56.00	05600	RADIOISOTOPE	0.094887	4,147	393	56.00
57.00	05700	CT SCAN	0.024687	108,107	2,669	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.054638	14,303	781	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.042882	0	0	59.00
60.00	06000	LABORATORY	0.066045	967,247	63,882	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.145920	3,594	524	62.00
65.00	06500	RESPIRATORY THERAPY	0.109849	113,957	12,518	65.00
66.00	06600	PHYSICAL THERAPY	0.300337	14,579	4,379	66.00
69.00	06900	ELECTROCARDIOLOGY	0.079960	64,299	5,141	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.101047	3,356	339	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.197403	15,105	2,982	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317668	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.149380	1,003,920	149,966	73.00
74.00	07400	RENAL DIALYSIS	0.182898	0	0	74.00
76.00	03950	LITHOTRIPSY	0.095596	0	0	76.00
76.01	03330	ENDOSCOPY	0.051660	5,400	279	76.01
76.02	03040	PRISION CLINIC	0.917760	0	0	76.02
76.03	03050	WOUND CARE	0.417668	0	0	76.03
76.04	03060	OPIC	0.199351	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.088932	1,093,971	97,289	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.970113	5,136	4,983	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,466,529	355,939	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		3,466,529		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-3 | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		315,815		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.094052	231,782	21,800	50.00
51.00	05100	RECOVERY ROOM	0.077120	7,427	573	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.445780	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246485	14,032	3,459	54.00
54.01	03630	ULTRA SOUND	0.079672	1,347	107	54.01
54.02	03440	MAMMOGRAPHY	0.267403	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.111551	24,954	2,784	55.00
56.00	05600	RADIOISOTOPE	0.094887	0	0	56.00
57.00	05700	CT SCAN	0.024687	37,677	930	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.054638	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.042882	0	0	59.00
60.00	06000	LABORATORY	0.066045	96,549	6,377	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.145920	38,631	5,637	62.00
65.00	06500	RESPIRATORY THERAPY	0.109849	44,922	4,935	65.00
66.00	06600	PHYSICAL THERAPY	0.300337	301,231	90,471	66.00
69.00	06900	ELECTROCARDIOLOGY	0.079960	11,196	895	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.101047	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.197403	71,174	14,050	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317668	47,198	14,993	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.149380	309,409	46,220	73.00
74.00	07400	RENAL DIALYSIS	0.182898	59,763	10,931	74.00
76.00	03950	LITHOTRIPSY	0.095596	0	0	76.00
76.01	03330	ENDOSCOPY	0.051660	0	0	76.01
76.02	03040	PRISION CLINIC	0.917760	0	0	76.02
76.03	03050	WOUND CARE	0.417668	0	0	76.03
76.04	03060	OPIC	0.199351	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.088932	31,761	2,825	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.970113	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,329,053	226,987	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,329,053		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet E Part A Date/Time Prepared: 1/30/2019 11:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,791,657	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	19,918,771	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)	594,046	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	3,374,087	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	158.29	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.39	30.00
31.00	Percentage of Medicaid patient days (see instructions)	22.25	31.00
32.00	Sum of lines 30 and 31	27.64	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.02	33.00
34.00	Disproportionate share adjustment (see instructions)	652,398	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet E Part A Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000121143	0.000093885	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	724,129	635,294	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	59,518	583,078	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	642,596		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)	23,599,468		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)	23,599,468	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,916,319	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	6,110	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)	25,521,897	59.00
60.00	Primary payer payments	5,735	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	25,516,162	61.00
62.00	Deductibles billed to program beneficiaries	2,278,912	62.00
63.00	Coinsurance billed to program beneficiaries	59,969	63.00
64.00	Allowable bad debts (see instructions)	170,432	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	110,781	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	66,790	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	23,288,062	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)	-27,636	70.93
70.94	HRR adjustment amount (see instructions)	-180,247	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet E Part A Date/Time Prepared: 1/30/2019 11:15 am
	Title XVIII	Hospital	PPS

Line	Description	FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		23,080,179	71.00
71.01	Sequestration adjustment (see instructions)		461,604	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		22,500,007	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)		118,568	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		646,606	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

Line	Description	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: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet E Part B Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	10,931	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	14,486,238	2.00
3.00	OPPS payments	14,625,261	3.00
4.00	Outlier payment (see instructions)	68,119	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)	10,931	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	73,176	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)	73,176	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)	73,176	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	62,245	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)	10,931	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)	14,693,380	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,762,313	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)	11,941,998	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)	11,941,998	30.00
31.00	Primary payer payments	3,456	31.00
32.00	Subtotal (line 30 minus line 31)	11,938,542	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)	500,240	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	325,156	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	396,514	36.00
37.00	Subtotal (see instructions)	12,263,698	37.00
38.00	MSP-LCC reconciliation amount from PS&R	59	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)	12,263,639	40.00
40.01	Sequestration adjustment (see instructions)	245,273	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	11,873,171	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	145,195	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: 15-0046 Component CCN: 15-S046	Period: From 09/01/2017 To 08/31/2018	Worksheet E Part B Date/Time Prepared: 1/30/2019 11:15 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,133	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	891	2.00
3.00	OPPS payments	1,202	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)	1,133	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	7,588	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)	7,588	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)	7,588	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	6,455	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	1,133	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	1,202	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,335	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)	2,335	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,335	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)	2,335	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)	2,335	40.00
40.01	Sequestration adjustment (see instructions)	47	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,665	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-377	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: 15-0046 Component CCN: 15-T046	Period: From 09/01/2017 To 08/31/2018	Worksheet E Part B Date/Time Prepared: 1/30/2019 11:15 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	409	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	500	2.00
3.00	OPPS payments	556	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)	409	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,741	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)	2,741	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)	2,741	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,332	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)	409	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)	556	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	20	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)	945	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)	945	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	945	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)	945	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)	945	40.00
40.01	Sequestration adjustment (see instructions)	19	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,062	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-136	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: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		22,500,007		11,873,171	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)		22,500,007		11,873,171	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		118,568		145,195	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		22,618,575		12,018,366	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: 15-0046 Component CCN: 15-S046	Period: From 09/01/2017 To 08/31/2018	Worksheet E-1 Part I Date/Time Prepared: 1/30/2019 11:15 am
	Title XVIII	Subprovider - IPF	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		972,668		2,665	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)		972,668		2,665	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		10,131		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		377	6.02
7.00	Total Medicare program liability (see instructions)		982,799		2,288	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: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 1/30/2019 11:15 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,054,415		1,062	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)		2,054,415		1,062	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		6,694		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		136	6.02
7.00	Total Medicare program liability (see instructions)		2,061,109		926	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: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet E-1 Part II Date/Time Prepared: 1/30/2019 11:15 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2017 To 08/31/2018	Worksheet E-3 Part II Date/Time Prepared: 1/30/2019 11:15 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,188,999	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see 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)	18.076712	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)	1,188,999	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)	1,188,999	16.00
17.00	Primary payer payments	6,546	17.00
18.00	Subtotal (line 16 less line 17).	1,182,453	18.00
19.00	Deductibles	182,332	19.00
20.00	Subtotal (line 18 minus line 19)	1,000,121	20.00
21.00	Coinsurance	7,603	21.00
22.00	Subtotal (line 20 minus line 21)	992,518	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	15,905	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	10,338	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)	1,002,856	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)	1,002,856	31.00
31.01	Sequestration adjustment (see instructions)	20,057	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	972,668	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)	10,131	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2017 To 08/31/2018	Worksheet E-3 Part III Date/Time Prepared: 1/30/2019 11:15 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	1,754,306	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0343	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	106,486	3.00
4.00	Outlier Payments	266,787	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	5.736986	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	2,127,579	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	2,127,579	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	2,127,579	19.00
20.00	Deductibles	14,692	20.00
21.00	Subtotal (line 19 minus line 20)	2,112,887	21.00
22.00	Coinsurance	9,715	22.00
23.00	Subtotal (line 21 minus line 22)	2,103,172	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	2,103,172	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	2,103,172	32.00
32.01	Sequestration adjustment (see instructions)	42,063	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	2,054,415	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	6,694	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	266,787	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: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 1/30/2019 11:15 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	6,875,503		1.00
2.00	Medical and other services		8,286,571	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	6,875,503	8,286,571	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)	6,875,503	8,286,571	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	41,256,934	75,775,003	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	41,256,934	75,775,003	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	41,256,934	75,775,003	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	34,381,431	67,488,432	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)	6,875,503	8,286,571	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)	6,875,503	8,286,571	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)	6,875,503	8,286,571	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)	6,875,503	8,286,571	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	6,875,503	8,286,571	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)	6,875,503	8,286,571	40.00
41.00	Interim payments	10,673,045	7,355,019	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-3,797,542	931,552	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: 15-0046 Component CCN: 15-S046	Period: From 09/01/2017 To 08/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 1/30/2019 11:15 am
	Title XIX	Subprovider - IPF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	2,501,523		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)	2,501,523	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)	2,501,523	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	3,466,529	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)	3,466,529	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)	3,466,529	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	965,006	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)	2,501,523	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)	2,501,523	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)	2,501,523	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)	2,501,523	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	2,501,523	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)	2,501,523	0	40.00
41.00	Interim payments	2,407,413	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	94,110	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: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet E-3 Part VII | Date/Time Prepared: 1/30/2019 11:15 am

Title XIX | Subprovider - IRF | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	350,920		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)	350,920	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)	350,920	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	1,329,053	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)	1,329,053	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)	1,329,053	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	978,133	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)	350,920	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)	350,920	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)	350,920	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)	350,920	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	350,920	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)	350,920	0	40.00
41.00	Interim payments	358,644	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-7,724	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)	Provider CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet G Date/Time Prepared: 1/30/2019 11:15 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	16,897	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	36,188,541	0	0	0	4.00
5.00	Other receivable	15,675	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,113,584	0	0	0	6.00
7.00	Inventory	7,026,956	0	0	0	7.00
8.00	Prepaid expenses	1,071,521	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-7,010	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	31,198,996	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,262,718	0	0	0	12.00
13.00	Land improvements	3,158,371	0	0	0	13.00
14.00	Accumulated depreciation	-3,054,391	0	0	0	14.00
15.00	Buildings	38,638,215	0	0	0	15.00
16.00	Accumulated depreciation	-26,768,240	0	0	0	16.00
17.00	Leasehold improvements	8,121,216	0	0	0	17.00
18.00	Accumulated depreciation	-6,242,960	0	0	0	18.00
19.00	Fixed equipment	26,985,459	0	0	0	19.00
20.00	Accumulated depreciation	-20,575,747	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	43,685,632	0	0	0	23.00
24.00	Accumulated depreciation	-34,399,898	0	0	0	24.00
25.00	Minor equipment depreciable	4,746,330	0	0	0	25.00
26.00	Accumulated depreciation	-3,624,977	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	5,042,581	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	36,974,309	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,063,197	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	2,386,484	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,449,681	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	73,622,986	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,042,639	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,655,653	0	0	0	38.00
39.00	Payroll taxes payable	3,209,369	0	0	0	39.00
40.00	Notes and loans payable (short term)	174,064	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	207	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,081,932	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	277,811	0	0	0	47.00
48.00	Unsecured loans	-227,733,846	0	0	0	48.00
49.00	Other long term liabilities	61,916	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-227,394,119	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-216,312,187	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	289,935,173				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)	289,935,173	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	73,622,986	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet G-1 Date/Time Prepared: 1/30/2019 11:15 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		275,280,739		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		17,667,895				2.00
3.00	Total (sum of line 1 and line 2)		292,948,634		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)		292,948,634		0		11.00
12.00	FEDERAL TAX LIABILITY ENTRY	3,013,409		0		0	12.00
13.00	ROUNDING	52		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)		3,013,461		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		289,935,173		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	FEDERAL TAX LIABILITY ENTRY		0		12.00
13.00	ROUNDING		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: 15-0046 | Period: From 09/01/2017 To 08/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 1/30/2019 11:15 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	22,510,917		22,510,917	1.00
2.00	SUBPROVIDER - IPF	25,931,452		25,931,452	2.00
3.00	SUBPROVIDER - IRF	2,810,229		2,810,229	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	51,252,598		51,252,598	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	10,170,730		10,170,730	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	NEONATAL INTENSIVE CARE UNIT				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	10,170,730		10,170,730	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	61,423,328		61,423,328	17.00
18.00	Ancillary services	296,319,435	349,456,650	645,776,085	18.00
19.00	Outpatient services	20,385,297	46,825,055	67,210,352	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	OCCUPATIONAL MEDICINE	0	421,555	421,555	27.00
27.01	ROUNDING	100	0	100	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	378,128,160	396,703,260	774,831,420	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		125,381,920		29.00
30.00	ROUNDING	23			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)		23		36.00
37.00	GAIN/LOSS ON DISPOSAL	1,415			37.00
38.00	INTEREST INCOME	88,209			38.00
39.00	UNCLAIMED PROPERTY	3,567			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		93,191		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		125,288,752		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet G-3 Date/Time Prepared: 1/30/2019 11:15 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	774,831,420	1.00
2.00	Less contractual allowances and discounts on patients' accounts	632,170,813	2.00
3.00	Net patient revenues (line 1 minus line 2)	142,660,607	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	125,288,752	4.00
5.00	Net income from service to patients (line 3 minus line 4)	17,371,855	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	MISCELLANEOUS INCOME	296,040	24.00
25.00	Total other income (sum of lines 6-24)	296,040	25.00
26.00	Total (line 5 plus line 25)	17,667,895	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)	17,667,895	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet L Parts I-III Date/Time Prepared: 1/30/2019 11:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,760,482	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	54,433	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)	54.24	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	5.39	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	22.25	8.00
9.00	Sum of lines 7 and 8	27.64	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.76	10.00
11.00	Disproportionate share adjustment (see instructions)	101,404	11.00
12.00	Total prospective capital payments (see instructions)	1,916,319	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