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: 15-0150	Period: From 04/01/2018 To 03/31/2019	Worksheet S Parts I-III Date/Time Prepared: 9/3/2019 3:51 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/3/2019 Time: 3:51 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DUPONT HOSPITAL (15-0150) for the cost reporting period beginning 04/01/2018 and ending 03/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

VICE PRESIDENT - REIMBURSEMENT
Title

Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	175,258	-2,972	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	175,258	-2,972	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 9/3/2019 3:51 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2520 E. DUPONT ROAD	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46825-	County: ALLEN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	DUPONT HOSPITAL	150150	23060	1	05/24/2001	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									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)	04/01/2018	03/31/2019	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.	538	623	27	151	5,249	283	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 9/3/2019 3:51 pm

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 9/3/2019 3:51 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 9/3/2019 3:51 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0150	Period: From 04/01/2018 To 03/31/2019	Worksheet S-2 Part I Date/Time Prepared: 9/3/2019 3:51 pm

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

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 9/3/2019 3:51 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	326,378	184,143	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.03	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 9/3/2019 3:51 pm

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 9/3/2019 3:51 pm

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

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

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	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.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	06/20/2019	Y	06/20/2019	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 9/3/2019 3:51 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			Y	12/31/2017	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KUZIWA		TSIGA		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS, INC.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 465-3416		KUZIWA_TSIGA@CHS.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0150	Period: From 04/01/2018 To 03/31/2019	Worksheet S-2 Part II Date/Time Prepared: 9/3/2019 3:51 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 9/3/2019 3:51 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	92	33,580	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)		92	33,580	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
8.01	NEONATAL INTENSIVE CARE UNIT	31.01	29	10,585	0.00	0	8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		131	47,815	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		131				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: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 9/3/2019 3:51 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,821	250	10,656			1.00
2.00	HMO and other (see instructions)	1,498	4,074				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,821	250	10,656			7.00
8.00	INTENSIVE CARE UNIT	191	12	631			8.00
8.01	NEONATAL INTENSIVE CARE UNIT	0	115	4,978			8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		2,137	3,937			13.00
14.00	Total (see instructions)	2,012	2,514	20,202	0.00	575.65	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	575.65	27.00
28.00	Observation Bed Days		0	1,918			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	283	945			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 9/3/2019 3:51 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	535	877	4,488	1.00
2.00	HMO and other (see instructions)			369	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
8.01	NEONATAL INTENSIVE CARE UNIT						8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	535	877	4,488	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-3 Part II Date/Time Prepared: 9/3/2019 3:51 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	36,517,271	0	36,517,271	1,197,358.00	30.50	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)		21,048	531,196	552,244	14,580.00	37.88	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		342,416	0	342,416	5,216.00	65.65	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		256,017	0	256,017	1,646.00	155.54	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		3,583,674	0	3,583,674	122,713.00	29.20	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)		6,801,355	0	6,801,355			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		97,099	0	97,099			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)		706,365	0	706,365			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	216,837	0	216,837	7,331.00	29.58	26.00
27.00	Administrative & General	5.00	5,321,414	-708,762	4,612,652	155,172.00	29.73	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-3 Part II Date/Time Prepared: 9/3/2019 3:51 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		139,224	0	139,224	1,033.00	134.78	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	876,671	0	876,671	39,533.00	22.18	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	515,136	0	515,136	37,780.00	13.64	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,184,459	-453,792	730,667	40,242.00	18.16	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	453,792	453,792	29,921.00	15.17	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,995,005	157,251	2,152,256	56,167.00	38.32	38.00
39.00	Central Services and Supply	14.00	417,049	0	417,049	21,698.00	19.22	39.00
40.00	Pharmacy	15.00	1,684,450	0	1,684,450	33,774.00	49.87	40.00
41.00	Medical Records & Medical Records Library	16.00	289,818	0	289,818	14,217.00	20.39	41.00
42.00	Social Service	17.00	581,229	0	581,229	15,103.00	38.48	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-3 Part III Date/Time Prepared: 9/3/2019 3:51 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		36,656,495	0	36,656,495	1,198,391.00	30.59	1.00
2.00	Excluded area salaries (see instructions)		21,048	531,196	552,244	14,580.00	37.88	2.00
3.00	Subtotal salaries (line 1 minus line 2)		36,635,447	-531,196	36,104,251	1,183,811.00	30.50	3.00
4.00	Subtotal other wages & related costs (see inst.)		4,182,107	0	4,182,107	129,575.00	32.28	4.00
5.00	Subtotal wage-related costs (see inst.)		7,507,720	0	7,507,720	0.00	20.79	5.00
6.00	Total (sum of lines 3 thru 5)		48,325,274	-531,196	47,794,078	1,313,386.00	36.39	6.00
7.00	Total overhead cost (see instructions)		13,221,292	-551,511	12,669,781	451,971.00	28.03	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-3 Part IV Date/Time Prepared: 9/3/2019 3:51 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	713,462	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,196,768	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	23,561	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	24,210	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	117	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	3,792	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	273,291	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	2,080,690	17.00
18.00	Medicare Taxes - Employers Portion Only	486,613	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	95,950	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,898,454	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: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-3 Part V | Date/Time Prepared: 9/3/2019 3:51 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	342,416	6,898,454	1.00
2.00	Hospital	342,416	6,898,454	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet S-10 | Date/Time Prepared: 9/3/2019 3:51 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.148434	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	14,911,348	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	104,464,358	6.00
7.00	Medicaid cost (line 1 times line 6)	15,506,063	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	594,715	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)	13,293	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	153,106	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	22,726	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)	9,433	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)	604,148	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)	4,318,610	10,766	4,329,376	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	641,029	10,766	651,795	21.00
22.00	Payments received from patients for amounts previously written off as charity care	675	0	675	22.00
23.00	Cost of charity care (line 21 minus line 22)	640,354	10,766	651,120	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,978,256	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	155,405	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	239,085	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,739,171	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	341,832	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	992,952	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,597,100	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet A | Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,463,217	1,463,217	1,471,945	2,935,162	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,289,617	3,289,617	2,310,064	5,599,681	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	216,837	200,339	417,176	4,305,858	4,723,034	4.00
5.01	00570	ADMITTING	0	0	0	2,435,891	2,435,891	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	2,206,225	2,206,225	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	5,321,414	41,508,498	46,829,912	-12,038,150	34,791,762	5.03
7.00	00700	OPERATION OF PLANT	876,671	3,160,807	4,037,478	679,352	4,716,830	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	471,780	471,780	0	471,780	8.00
9.00	00900	HOUSEKEEPING	515,136	511,894	1,027,030	-3,402	1,023,628	9.00
10.00	01000	DIETARY	1,184,459	1,042,550	2,227,009	-993,428	1,233,581	10.00
11.00	01100	CAFETERIA	0	0	0	976,940	976,940	11.00
13.00	01300	NURSING ADMINISTRATION	1,995,005	248,713	2,243,718	153,061	2,396,779	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	417,049	14,828,902	15,245,951	-13,450,403	1,795,548	14.00
15.00	01500	PHARMACY	1,684,450	4,562,638	6,247,088	-4,483,666	1,763,422	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	289,818	807,408	1,097,226	-18,355	1,078,871	16.00
17.00	01700	SOCIAL SERVICE	581,229	45,962	627,191	-4	627,187	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,500,920	1,847,452	9,348,372	-3,184,596	6,163,776	30.00
31.00	03100	INTENSIVE CARE UNIT	1,047,434	937,298	1,984,732	-43	1,984,689	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	2,471,024	691,422	3,162,446	-4,840	3,157,606	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	527	150,918	151,445	1,182,038	1,333,483	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,253,912	5,301,924	8,555,836	1,652,917	10,208,753	50.00
51.00	05100	RECOVERY ROOM	2,058,087	713,144	2,771,231	-2,771,231	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-2,946	915,298	912,352	1,978,018	2,890,370	52.00
53.00	05300	ANESTHESIOLOGY	0	1,494,876	1,494,876	-1,282	1,493,594	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,869,495	1,081,219	2,950,714	-364,226	2,586,488	54.00
54.01	05401	ULTRA SOUND	379,551	36,317	415,868	0	415,868	54.01
56.00	05600	RADIOISOTOPE	101,624	154,971	256,595	-21,150	235,445	56.00
57.00	05700	CT SCAN	0	43,240	43,240	-43,240	0	57.00
58.00	05800	MRI	191,125	148,465	339,590	-114,500	225,090	58.00
60.00	06000	LABORATORY	1,598,282	1,486,324	3,084,606	-192,693	2,891,913	60.00
65.00	06500	RESPIRATORY THERAPY	979,137	482,349	1,461,486	-817	1,460,669	65.00
66.00	06600	PHYSICAL THERAPY	155,291	38,348	193,639	194,717	388,356	66.00
67.00	06700	OCCUPATIONAL THERAPY	107,316	8,137	115,453	-115,453	0	67.00
68.00	06800	SPEECH PATHOLOGY	73,242	6,022	79,264	-79,264	0	68.00
69.00	06900	ELECTROCARDIOLOGY	16,218	24,824	41,042	0	41,042	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,081,195	2,081,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,346,961	11,346,961	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,306,497	4,306,497	73.00
74.00	07400	RENAL DIALYSIS	0	179,473	179,473	0	179,473	74.00
76.00	03950	SLEEP LAB	172,315	819,027	991,342	-388	990,954	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	1,427	108	1,535	-1,535	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	331,845	112,249	444,094	-258	443,836	90.00
91.00	09100	EMERGENCY	1,108,329	1,176,891	2,285,220	305,870	2,591,090	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	20,315	287,225	307,540	-307,540	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,516,538	90,279,846	126,796,384	-602,915	126,193,469	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	733	16,836	17,569	-2,088	15,481	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	0	0	605,003	605,003	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	36,517,271	90,296,682	126,813,953	0	126,813,953	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet A | Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	968,958	3,904,120		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,120,722	6,720,403		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,920	4,716,114		4.00
5.01	00570	ADMITTING	0	2,435,891		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	-664,001	1,542,224		5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-14,515,774	20,275,988		5.03
7.00	00700	OPERATION OF PLANT	-27,356	4,689,474		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	471,780		8.00
9.00	00900	HOUSEKEEPING	0	1,023,628		9.00
10.00	01000	DIETARY	0	1,233,581		10.00
11.00	01100	CAFETERIA	-396,052	580,888		11.00
13.00	01300	NURSING ADMINISTRATION	-2,317	2,394,462		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,795,548		14.00
15.00	01500	PHARMACY	0	1,763,422		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-681	1,078,190		16.00
17.00	01700	SOCIAL SERVICE	0	627,187		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-807,946	5,355,830		30.00
31.00	03100	INTENSIVE CARE UNIT	-527,966	1,456,723		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	-84,746	3,072,860		31.01
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
43.00	04300	NURSERY	0	1,333,483		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-12,940	10,195,813		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-416,075	2,474,295		52.00
53.00	05300	ANESTHESIOLOGY	-1,493,594	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-63,247	2,523,241		54.00
54.01	05401	ULTRA SOUND	0	415,868		54.01
56.00	05600	RADIOISOTOPE	0	235,445		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	225,090		58.00
60.00	06000	LABORATORY	-85,770	2,806,143		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,460,669		65.00
66.00	06600	PHYSICAL THERAPY	0	388,356		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	41,042		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,081,195		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,346,961		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,306,497		73.00
74.00	07400	RENAL DIALYSIS	0	179,473		74.00
76.00	03950	SLEEP LAB	-773,930	217,024		76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	443,836		90.00
91.00	09100	EMERGENCY	-577,137	2,013,953		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-18,366,772	107,826,697		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,481		192.00
194.00	07950	MARKETING	0	0		194.00
194.01	07951	PHYSICIAN RELATIONS	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0		194.02
194.03	07953	WOMENS RESOURCE CENTER	0	605,003		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-18,366,772	108,447,181		200.00

RECLASSIFICATIONS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet A-6 | Date/Time Prepared: 9/3/2019 3:51 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFIT RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,306,162	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	4,306,162	
	B - RENTAL AND LEASE EXPENSES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	67,005	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,304,043	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
	TOTALS		0	2,371,048	
	C - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	104,573	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,300,367	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,021	3.00
	TOTALS		0	1,410,961	
	D - REPAIRS & MAINTENANCE				
1.00	OPERATION OF PLANT	7.00	0	679,352	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	TOTALS		0	679,352	
	E - CNO SALARIES				
1.00	NURSING ADMINISTRATION	13.00	157,251	0	1.00
	TOTALS		157,251	0	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,081,195	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	11,346,961	2.00
	TOTALS		0	13,428,156	
	G - DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,306,497	1.00
	TOTALS		0	4,306,497	
	H - LABOR & DELIVERY COSTS				
1.00	ADULTS & PEDIATRICS	30.00	0	86,789	1.00
2.00	NURSERY	43.00	1,023,954	158,084	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	2,225,707	0	3.00
	TOTALS		3,249,661	244,873	
	I - MISCELLANEOUS				
1.00	ADMITTING	5.01	2,153,789	282,102	1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.02	0	2,206,225	2.00

RECLASSIFICATIONS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet A-6 | Date/Time Prepared: 9/3/2019 3:51 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	TOTALS		2,153,789	2,488,327		
	J - RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	43,240		1.00
	TOTALS		0	43,240		
	K - DIETARY					
1.00	CAFETERIA	11.00	453,792	523,148		1.00
	TOTALS		453,792	523,148		
	L - MISC DEPT RECLASS					
1.00	OPERATING ROOM	50.00	2,059,514	709,371		1.00
2.00	PHYSICAL THERAPY	66.00	180,558	14,159		2.00
3.00	EMERGENCY	91.00	20,315	287,225		3.00
4.00	WOMENS RESOURCE CENTER	194.03	551,511	53,492		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
	TOTALS		2,811,898	1,064,247		
500.00	Grand Total: Increases		8,826,391	30,866,011		500.00

RECLASSIFICATIONS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet A-6 | Date/Time Prepared: 9/3/2019 3:51 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFIT RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	4,304,596	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	1,566	0		2.00
	TOTALS		0	4,306,162			
	B - RENTAL AND LEASE EXPENSES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	264	10		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	773,368	10		2.00
3.00	HOUSEKEEPING	9.00	0	918	0		3.00
4.00	DIETARY	10.00	0	3,738	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	1,946	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	266,809	0		6.00
7.00	PHARMACY	15.00	0	117,384	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	18,355	0		8.00
9.00	SOCIAL SERVICE	17.00	0	4	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	21,244	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	36	0		11.00
12.00	OPERATING ROOM	50.00	0	612,505	0		12.00
13.00	RECOVERY ROOM	51.00	0	250	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	321,571	0		14.00
15.00	MRI	58.00	0	114,500	0		15.00
16.00	LABORATORY	60.00	0	117,352	0		16.00
17.00	SLEEP LAB	76.00	0	383	0		17.00
18.00	EMERGENCY	91.00	0	300	0		18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	121	0		19.00
	TOTALS		0	2,371,048			
	C - OTHER CAPITAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	1,410,961	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	1,410,961			
	D - REPAIRS & MAINTENANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40	0		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	144,855	0		2.00
3.00	HOUSEKEEPING	9.00	0	2,484	0		3.00
4.00	DIETARY	10.00	0	12,750	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	678	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	128,148	0		6.00
7.00	PHARMACY	15.00	0	59,785	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	480	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	7	0		9.00
10.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	4,840	0		10.00
11.00	OPERATING ROOM	50.00	0	130,753	0		11.00
12.00	RECOVERY ROOM	51.00	0	4,913	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	2,816	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	85,895	0		14.00
15.00	RADIOISOTOPE	56.00	0	21,150	0		15.00
16.00	LABORATORY	60.00	0	75,341	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	817	0		17.00
18.00	SLEEP LAB	76.00	0	5	0		18.00
19.00	CLINIC	90.00	0	258	0		19.00
20.00	EMERGENCY	91.00	0	1,370	0		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,967	0		21.00
	TOTALS		0	679,352			
	E - CNO SALARIES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	157,251	0	0		1.00
	TOTALS		157,251	0			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	13,055,446	0		1.00
2.00	OPERATING ROOM	50.00	0	372,710	0		2.00
	TOTALS		0	13,428,156			
	G - DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	4,306,497	0		1.00
	TOTALS		0	4,306,497			
	H - LABOR & DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	3,249,661	0	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	244,873	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		3,249,661	244,873			

RECLASSIFICATIONS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet A-6 | Date/Time Prepared: 9/3/2019 3:51 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	I - MISCELLANEOUS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	2,153,789	2,488,327	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		2,153,789	2,488,327			
	J - RADIOLOGY COSTS						
1.00	CT SCAN	57.00	0	43,240	0		1.00
	TOTALS		0	43,240			
	K - DIETARY						
1.00	DIETARY	10.00	453,792	523,148	0		1.00
	TOTALS		453,792	523,148			
	L - MISC DEPT RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	551,511	53,492	0		1.00
2.00	RECOVERY ROOM	51.00	2,058,087	707,981	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	1,282	0		3.00
4.00	OCCUPATIONAL THERAPY	67.00	107,316	8,137	0		4.00
5.00	SPEECH PATHOLOGY	68.00	73,242	6,022	0		5.00
6.00	PSYCH SERVICES/EATINT DISORDER	76.02	1,427	108	0		6.00
7.00	AMBULANCE SERVICES	95.00	20,315	287,225	0		7.00
	TOTALS		2,811,898	1,064,247			
500.00	Grand Total: Decreases		8,826,391	30,866,011			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet A-7 Part I Date/Time Prepared: 9/3/2019 3:51 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,732,541	0	0	0	0	1.00
2.00	Land Improvements	468,977	0	0	0	0	2.00
3.00	Buildings and Fixtures	55,764,094	1,006	0	1,006	0	3.00
4.00	Building Improvements	7,208,703	3,526,820	0	3,526,820	0	4.00
5.00	Fixed Equipment	3,819,369	217,663	0	217,663	732	5.00
6.00	Movable Equipment	60,665,222	5,994,233	0	5,994,233	2,726,623	6.00
7.00	HIT designated Assets	379,739	1,727	0	1,727	0	7.00
8.00	Subtotal (sum of lines 1-7)	130,038,645	9,741,449	0	9,741,449	2,727,355	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	130,038,645	9,741,449	0	9,741,449	2,727,355	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,732,541	0	1.00
2.00	Land Improvements	468,977	0	2.00
3.00	Buildings and Fixtures	55,765,100	0	3.00
4.00	Building Improvements	10,735,523	0	4.00
5.00	Fixed Equipment	4,036,300	0	5.00
6.00	Movable Equipment	63,932,832	0	6.00
7.00	HIT designated Assets	381,466	0	7.00
8.00	Subtotal (sum of lines 1-7)	137,052,739	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	137,052,739	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 9/3/2019 3:51 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,463,217	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,289,617	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,752,834	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,463,217		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,289,617		2.00
3.00	Total (sum of lines 1-2)	0	4,752,834		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet A-7 Part III Date/Time Prepared: 9/3/2019 3:51 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	73,119,907	0	73,119,907	0.533517	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	63,932,832	0	63,932,832	0.466483	0	2.00
3.00	Total (sum of lines 1-2)	137,052,739	0	137,052,739	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,270,128	-11,241	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,192,529	2,521,853	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,462,657	2,510,612	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	240,293	104,573	1,300,367	0	3,904,120	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,021	0	0	6,720,403	2.00
3.00	Total (sum of lines 1-2)	240,293	110,594	1,300,367	0	10,624,523	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet A-8 | Date/Time Prepared: 9/3/2019 3:51 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-53,559	OTHER ADMINISTRATIVE AND GENERAL	5.03	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	-4,898,689			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	121,459			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-396,052	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-681	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	727,272	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	565,906	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	SILVER RECOVERY	B	-147	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet A-8 | Date/Time Prepared: 9/3/2019 3:51 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
35.00	RENTAL INCOME	B	-78,246	CAP REL COSTS-BLDG & FIXT	1.00	10	35.00
36.00	MISC INCOME	B	-607,014	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	36.00
38.00	TRAINING REVENUE	B	-500	NURSING ADMINISTRATION	13.00	0	38.00
39.00	PATIENT PHONE BENEFITS COST	A	-6,920	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
40.00	PHOTO COMMISSION	B	-1,732	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	40.00
41.00	PATIENT TV EXPENSE	A	-27,356	OPERATION OF PLANT	7.00	0	41.00
42.00	MARKETING EXPENSE	A	-8,444	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	42.00
42.01	MARKETING DEPARTMENT	A	-1,103,861	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	42.01
43.00	MINORITY INTEREST	A	-11,496,662	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	43.00
44.00	PHYSICIAN RECRUITING	A	-389,216	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	44.00
45.00	NON-RESTRICTED DONATIONS	B	-385	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.00
45.01	CHARITABLE CONTRIBUTIONS	A	-76,241	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.01
45.02	MEALS & ENTERTAINMENT	A	-42,258	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.02
45.03	MOB SUPPORT COSTS	A	-402,936	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.03
45.04	LEGAL FEES	A	-45,289	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.04
45.05	VALET PARKING	A	-145,221	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-18,366,772				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: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 9/3/2019 3:51 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL- RELATED INTEREST	240,293	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	27,037	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	4,701	0	3.00
4.00	5.03	OTHER ADMINISTRATIVE AND GEN	PASI OPERATING COSTS	425,669	0	4.00
4.01	5.03	OTHER ADMINISTRATIVE AND GEN	SHARED SERVICE CENTER ALLOCA	1,879,235	944,713	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	52,602	0	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	332,305	0	4.03
4.04	5.03	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL HOME OFFICE COST	3,366,071	0	4.04
4.05	5.03	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE COSTS	510,521	1,033,554	4.05
4.06	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	13,916	114,714	4.06
4.07	5.03	OTHER ADMINISTRATIVE AND GEN	LAUNDRY - OPERATING	298,258	227,357	4.07
4.08	5.03	OTHER ADMINISTRATIVE AND GEN	LAUNDRY - CAPITAL	35,440	243,011	4.08
4.09	2.00	CAP REL COSTS-MVBLE EQUIP	DSC BLDG LEASE SJH	721,544	402,936	4.09
4.10	5.03	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEES	0	1,896,143	4.10
4.11	5.03	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	5,263	4.11
4.12	5.03	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	214,977	4.12
4.13	5.03	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIO	0	1,532,240	4.13
4.14	5.03	OTHER ADMINISTRATIVE AND GEN	HIIM ALLOCATION	0	469,598	4.14
4.15	5.03	OTHER ADMINISTRATIVE AND GEN	PASI LIEN UNIT COLLECTION FE	0	37,626	4.15
4.16	5.02	CASHIERING/ACCOUNTS RECEIVAB	PASI LIEN UNIT	0	664,001	4.16
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,907,592	7,786,133	5.00

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

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

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

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

6.00	B	CHS, INC.	72.03	CHS, INC.	72.03	6.00
7.00	B	HOSPITAL LAUNDR	100.00	HOSPITAL LAUNDR	100.00	7.00
8.00	B	LUTHERAN HEALTH	100.00	LUTHERAN HEALTH	100.00	8.00
9.00	B	PASI	100.00	PASI	100.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 9/3/2019 3:51 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	240,293	11		1.00
2.00	27,037	9		2.00
3.00	4,701	9		3.00
4.00	425,669	0		4.00
4.01	934,522	0		4.01
4.02	52,602	9		4.02
4.03	332,305	9		4.03
4.04	3,366,071	0		4.04
4.05	-523,033	0		4.05
4.06	-100,798	10		4.06
4.07	70,901	0		4.07
4.08	-207,571	0		4.08
4.09	318,608	10		4.09
4.10	-1,896,143	0		4.10
4.11	-5,263	0		4.11
4.12	-214,977	0		4.12
4.13	-1,532,240	0		4.13
4.14	-469,598	0		4.14
4.15	-37,626	0		4.15
4.16	-664,001	0		4.16
5.00	121,459			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HOSPITAL MANAGEMENT		6.00
7.00	LAUNDRY		7.00
8.00	HOSPITAL NETWOR		8.00
9.00	DEBT COLLECTION		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 9/3/2019 3:51 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	53,668	53,668	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	1,817	1,817	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	807,946	807,946	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	527,966	527,966	0	0	0	4.00
5.00	31.01	NEONATAL INTENSIVE CARE UNIT	84,746	84,746	0	0	0	5.00
6.00	50.00	OPERATING ROOM	12,940	12,940	0	0	0	6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	416,075	416,075	0	0	0	7.00
8.00	53.00	ANESTHESIOLOGY	1,493,594	1,493,594	0	0	0	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	63,100	63,100	0	0	0	9.00
10.00	60.00	LABORATORY	85,770	85,770	0	0	0	10.00
11.00	76.00	SLEEP LAB	773,930	773,930	0	0	0	11.00
12.00	91.00	EMERGENCY	577,137	577,137	0	0	0	12.00
200.00			4,898,689	4,898,689	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	7.00
8.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	9.00
10.00	60.00	LABORATORY	0	0	0	0	0	10.00
11.00	76.00	SLEEP LAB	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	53,668		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	1,817		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	807,946		3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	527,966		4.00
5.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	84,746		5.00
6.00	50.00	OPERATING ROOM	0	0	0	12,940		6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	416,075		7.00
8.00	53.00	ANESTHESIOLOGY	0	0	0	1,493,594		8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	63,100		9.00
10.00	60.00	LABORATORY	0	0	0	85,770		10.00
11.00	76.00	SLEEP LAB	0	0	0	773,930		11.00
12.00	91.00	EMERGENCY	0	0	0	577,137		12.00
200.00			0	0	0	4,898,689		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B Part I Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,904,120	3,904,120				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	6,720,403		6,720,403			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,716,114	9,996	17,206	4,743,316		4.00
5.01	00570	ADMITTING	2,435,891	0	0	281,431	2,717,322	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,542,224	0	0	0	0	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	20,275,988	131,212	225,863	321,295	0	5.03
7.00	00700	OPERATION OF PLANT	4,689,474	1,080,840	1,860,520	114,553	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	471,780	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,023,628	12,113	20,851	67,312	0	9.00
10.00	01000	DIETARY	1,233,581	99,072	170,539	95,475	0	10.00
11.00	01100	CAFETERIA	580,888	0	0	59,296	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,394,462	20,634	35,518	281,231	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,795,548	36,720	63,209	54,495	0	14.00
15.00	01500	PHARMACY	1,763,422	0	0	220,104	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,078,190	12,946	22,285	37,870	0	16.00
17.00	01700	SOCIAL SERVICE	627,187	0	0	75,948	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,355,830	800,094	1,377,250	555,504	175,291	30.00
31.00	03100	INTENSIVE CARE UNIT	1,456,723	116,999	201,397	136,866	11,220	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	3,072,860	168,800	290,565	322,884	108,568	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	1,333,483	53,068	91,349	133,867	27,615	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,195,813	783,382	1,348,484	694,303	885,912	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,474,295	0	0	290,444	59,916	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,523,241	161,719	278,378	244,283	166,122	54.00
54.01	05401	ULTRA SOUND	415,868	0	0	49,595	34,299	54.01
56.00	05600	RADIOISOTOPE	235,445	0	0	13,279	17,661	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	225,090	29,918	51,499	24,974	28,295	58.00
60.00	06000	LABORATORY	2,806,143	34,187	58,848	208,844	198,993	60.00
65.00	06500	RESPIRATORY THERAPY	1,460,669	0	0	127,942	33,100	65.00
66.00	06600	PHYSICAL THERAPY	388,356	10,378	17,863	43,885	9,728	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	41,042	0	0	2,119	34,773	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,081,195	0	0	0	210,445	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,346,961	0	0	0	263,276	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,306,497	0	0	0	317,958	73.00
74.00	07400	RENAL DIALYSIS	179,473	0	0	0	3,245	74.00
76.00	03950	SLEEP LAB	217,024	38,803	66,794	22,516	8,402	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	443,836	0	0	43,362	10,342	90.00
91.00	09100	EMERGENCY	2,013,953	138,361	238,170	147,478	112,161	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	107,826,697	3,739,242	6,436,588	4,671,155	2,717,322	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,805	16,878	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,481	0	0	96	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	605,003	155,073	266,937	72,065	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	108,447,181	3,904,120	6,720,403	4,743,316	2,717,322	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B Part I | Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,542,224					5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	20,954,358	20,954,358			5.03
7.00	00700	OPERATION OF PLANT	0	7,745,387	1,855,005	9,600,392		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	471,780	112,990	0	584,770	8.00
9.00	00900	HOUSEKEEPING	0	1,123,904	269,173	43,358	0	9.00
10.00	01000	DIETARY	0	1,598,667	382,878	354,627	0	10.00
11.00	01100	CAFETERIA	0	640,184	153,323	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,731,845	654,271	73,857	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,949,972	467,014	131,440	1,055	14.00
15.00	01500	PHARMACY	0	1,983,526	475,051	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,151,291	275,732	46,339	0	16.00
17.00	01700	SOCIAL SERVICE	0	703,135	168,399	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	99,504	8,363,473	2,003,035	2,863,911	186,626	30.00
31.00	03100	INTENSIVE CARE UNIT	6,369	1,929,574	462,129	418,794	30,660	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	61,629	4,025,306	964,053	604,214	10,834	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	15,676	1,655,058	396,383	189,954	8,390	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	502,622	14,410,516	3,451,290	2,804,092	131,145	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,011	2,858,666	684,645	0	101,370	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94,299	3,468,042	830,589	578,870	47,795	54.00
54.01	05401	ULTRA SOUND	19,470	519,232	124,355	0	0	54.01
56.00	05600	RADIOISOTOPE	10,025	276,410	66,200	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	16,062	375,838	90,012	107,090	0	58.00
60.00	06000	LABORATORY	112,959	3,419,974	819,077	122,371	0	60.00
65.00	06500	RESPIRATORY THERAPY	18,789	1,640,500	392,896	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,522	475,732	113,937	37,146	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	19,739	97,673	23,392	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	119,460	2,411,100	577,454	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	149,449	11,759,686	2,816,421	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	180,490	4,804,945	1,150,775	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,842	184,560	44,202	0	0	74.00
76.00	03950	SLEEP LAB	4,769	358,308	85,814	138,894	9,624	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,870	503,410	120,566	0	0	90.00
91.00	09100	EMERGENCY	63,668	2,713,791	649,948	495,260	57,271	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,542,224	107,305,843	20,681,009	9,010,217	584,770	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,683	6,391	35,096	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,577	3,731	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	1,099,078	263,227	555,079	0	194.03
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,542,224	108,447,181	20,954,358	9,600,392	584,770	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B Part I | Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	1,436,435					9.00
10.00	01000	DIETARY	53,301	2,389,473				10.00
11.00	01100	CAFETERIA	0	0	793,507			11.00
13.00	01300	NURSING ADMINISTRATION	11,101	0	50,027	3,521,101		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,756	0	19,325	0	2,588,562	14.00
15.00	01500	PHARMACY	0	0	30,090	0	10,964	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,965	0	12,674	0	363	16.00
17.00	01700	SOCIAL SERVICE	0	0	13,452	0	256	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	430,450	1,039,534	122,678	1,517,414	48,815	30.00
31.00	03100	INTENSIVE CARE UNIT	62,945	44,337	26,274	195,845	16,622	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	90,814	315,374	63,535	553,852	41,208	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	28,550	200,777	26,514	0	18,533	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	421,459	0	154,992	857,007	458,580	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	57,531	2,910	57,824	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,005	0	50,287	97,297	44,865	54.00
54.01	05401	ULTRA SOUND	0	0	9,450	0	792	54.01
56.00	05600	RADIOISOTOPE	0	0	2,483	0	14,084	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	16,096	0	5,132	0	2,401	58.00
60.00	06000	LABORATORY	18,392	0	55,660	27,559	99,493	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	27,441	13,049	42,199	65.00
66.00	06600	PHYSICAL THERAPY	5,583	0	6,466	0	3,392	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	93	0	35	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	267,224	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,409,886	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	SLEEP LAB	20,876	0	6,281	12,686	3,810	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	7,226	0	10,737	90.00
91.00	09100	EMERGENCY	74,438	0	32,925	243,482	35,526	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,347,731	1,600,022	780,536	3,521,101	2,587,609	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,275	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	789,451	19	0	20	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	83,429	0	12,952	0	933	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)	1,436,435	2,389,473	793,507	3,521,101	2,588,562	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B Part I Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,499,631					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,493,364				16.00
17.00	01700	SOCIAL SERVICE	0	0	885,242			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	96,339	469,124	17,141,399	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,166	27,506	3,220,852	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	59,668	216,995	6,945,853	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	15,177	171,617	2,710,953	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	486,833	0	23,175,914	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	32,929	0	3,795,875	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	91,300	0	5,296,050	0	54.00
54.01	05401	ULTRA SOUND	0	18,851	0	672,680	0	54.01
56.00	05600	RADIOISOTOPE	0	9,706	0	368,883	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	15,551	0	612,120	0	58.00
60.00	06000	LABORATORY	0	109,365	0	4,671,891	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	18,192	0	2,134,277	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,346	0	647,602	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	19,111	0	140,304	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	115,659	0	3,371,437	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	144,695	0	16,130,688	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,499,631	174,748	0	8,630,099	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,783	0	230,545	0	74.00
76.00	03950	SLEEP LAB	0	4,618	0	640,911	0	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,684	0	647,623	0	90.00
91.00	09100	EMERGENCY	0	61,643	0	4,364,284	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,499,631	1,493,364	885,242	105,550,240	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	73,445	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	808,798	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	0	0	2,014,698	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)	2,499,631	1,493,364	885,242	108,447,181	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B Part I | Date/Time Prepared: 9/3/2019 3:51 pm

		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
5.01	00570	ADMITTING			5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL			5.03
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	17,141,399		30.00
31.00	03100	INTENSIVE CARE UNIT	3,220,852		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	6,945,853		31.01
40.00	04000	SUBPROVIDER - IPF	0		40.00
43.00	04300	NURSERY	2,710,953		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	23,175,914		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,795,875		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,296,050		54.00
54.01	05401	ULTRA SOUND	672,680		54.01
56.00	05600	RADIOISOTOPE	368,883		56.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MRI	612,120		58.00
60.00	06000	LABORATORY	4,671,891		60.00
65.00	06500	RESPIRATORY THERAPY	2,134,277		65.00
66.00	06600	PHYSICAL THERAPY	647,602		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	140,304		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,371,437		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,130,688		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,630,099		73.00
74.00	07400	RENAL DIALYSIS	230,545		74.00
76.00	03950	SLEEP LAB	640,911		76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0		76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	647,623		90.00
91.00	09100	EMERGENCY	4,364,284		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	105,550,240		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	73,445		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	808,798		192.00
194.00	07950	MARKETING	0		194.00
194.01	07951	PHYSICIAN RELATIONS	0		194.01
194.02	07952	SENIOR CIRCLE	0		194.02
194.03	07953	WOMENS RESOURCE CENTER	2,014,698		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)	108,447,181		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B Part II | Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,996	17,206	27,202	27,202	4.00
5.01	00570	ADMITTING	0	0	0	0	1,613	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	131,212	225,863	357,075	1,842	5.03
7.00	00700	OPERATION OF PLANT	0	1,080,840	1,860,520	2,941,360	657	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	12,113	20,851	32,964	386	9.00
10.00	01000	DIETARY	0	99,072	170,539	269,611	547	10.00
11.00	01100	CAFETERIA	0	0	0	0	340	11.00
13.00	01300	NURSING ADMINISTRATION	0	20,634	35,518	56,152	1,612	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	36,720	63,209	99,929	312	14.00
15.00	01500	PHARMACY	0	0	0	0	1,262	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,946	22,285	35,231	217	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	435	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	800,094	1,377,250	2,177,344	3,184	30.00
31.00	03100	INTENSIVE CARE UNIT	0	116,999	201,397	318,396	785	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	168,800	290,565	459,365	1,851	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	53,068	91,349	144,417	767	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	783,382	1,348,484	2,131,866	3,993	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	1,665	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	161,719	278,378	440,097	1,400	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	284	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	76	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	29,918	51,499	81,417	143	58.00
60.00	06000	LABORATORY	0	34,187	58,848	93,035	1,197	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	733	65.00
66.00	06600	PHYSICAL THERAPY	0	10,378	17,863	28,241	252	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	12	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0	38,803	66,794	105,597	129	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	249	90.00
91.00	09100	EMERGENCY	0	138,361	238,170	376,531	845	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,739,242	6,436,588	10,175,830	26,788	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,805	16,878	26,683	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	155,073	266,937	422,010	413	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)	0	3,904,120	6,720,403	10,624,523	27,202	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B Part II | Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	1,613					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0				5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	358,917			5.03
7.00	00700	OPERATION OF PLANT	0	0	31,772	2,973,789		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,935	0	1,935	8.00
9.00	00900	HOUSEKEEPING	0	0	4,610	13,430	0	9.00
10.00	01000	DIETARY	0	0	6,558	109,848	0	10.00
11.00	01100	CAFETERIA	0	0	2,626	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	11,206	22,878	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	7,999	40,714	3	14.00
15.00	01500	PHARMACY	0	0	8,136	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	4,723	14,354	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	2,884	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	92	0	34,307	887,119	618	30.00
31.00	03100	INTENSIVE CARE UNIT	6	0	7,915	129,724	101	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	57	0	16,512	187,159	36	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	14	0	6,789	58,840	28	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	656	0	59,134	868,587	434	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31	0	11,726	0	335	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87	0	14,226	179,309	158	54.00
54.01	05401	ULTRA SOUND	18	0	2,130	0	0	54.01
56.00	05600	RADIOISOTOPE	9	0	1,134	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	15	0	1,542	33,172	0	58.00
60.00	06000	LABORATORY	104	0	14,029	37,905	0	60.00
65.00	06500	RESPIRATORY THERAPY	17	0	6,729	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5	0	1,951	11,506	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	18	0	401	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	110	0	9,890	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	138	0	48,238	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	166	0	19,710	0	0	73.00
74.00	07400	RENAL DIALYSIS	2	0	757	0	0	74.00
76.00	03950	SLEEP LAB	4	0	1,470	43,023	32	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5	0	2,065	0	0	90.00
91.00	09100	EMERGENCY	59	0	11,132	153,410	190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,613	0	354,236	2,790,978	1,935	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	109	10,871	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	64	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	0	4,508	171,940	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)	1,613	0	358,917	2,973,789	1,935	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B Part II Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	51,390					9.00
10.00	01000	DIETARY	1,907	388,471				10.00
11.00	01100	CAFETERIA	0	0	2,966			11.00
13.00	01300	NURSING ADMINISTRATION	397	0	187	92,432		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	707	0	72	0	149,736	14.00
15.00	01500	PHARMACY	0	0	112	0	634	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	249	0	47	0	21	16.00
17.00	01700	SOCIAL SERVICE	0	0	50	0	15	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,399	169,003	459	39,838	2,824	30.00
31.00	03100	INTENSIVE CARE UNIT	2,252	7,208	98	5,141	961	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	3,249	51,272	237	14,538	2,384	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	1,021	32,642	99	0	1,072	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,078	0	583	22,495	26,526	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	215	76	3,345	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,113	0	188	2,554	2,595	54.00
54.01	05401	ULTRA SOUND	0	0	35	0	46	54.01
56.00	05600	RADIOISOTOPE	0	0	9	0	815	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	576	0	19	0	139	58.00
60.00	06000	LABORATORY	658	0	208	723	5,755	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	103	343	2,441	65.00
66.00	06600	PHYSICAL THERAPY	200	0	24	0	196	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	2	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	15,457	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	81,557	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	SLEEP LAB	747	0	23	333	220	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	27	0	621	90.00
91.00	09100	EMERGENCY	2,663	0	123	6,391	2,055	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,216	260,125	2,918	92,432	149,681	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	189	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	128,346	0	0	1	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	2,985	0	48	0	54	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)	51,390	388,471	2,966	92,432	149,736	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B Part II Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	10,144					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54,842				16.00
17.00	01700	SOCIAL SERVICE	0	0	3,384			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,532	1,793	3,335,512	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	226	105	472,918	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	2,188	830	739,678	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	557	656	246,902	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	17,938	0	3,147,290	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,207	0	18,600	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,348	0	647,075	0	54.00
54.01	05401	ULTRA SOUND	0	691	0	3,204	0	54.01
56.00	05600	RADIOISOTOPE	0	356	0	2,399	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	570	0	117,593	0	58.00
60.00	06000	LABORATORY	0	4,010	0	157,624	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	667	0	11,033	0	65.00
66.00	06600	PHYSICAL THERAPY	0	196	0	42,571	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	701	0	1,134	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,241	0	29,698	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,305	0	135,238	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,144	6,407	0	36,427	0	73.00
74.00	07400	RENAL DIALYSIS	0	65	0	824	0	74.00
76.00	03950	SLEEP LAB	0	169	0	151,747	0	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	208	0	3,175	0	90.00
91.00	09100	EMERGENCY	0	2,260	0	555,659	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,144	54,842	3,384	9,856,301	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	37,852	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	128,412	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	0	0	601,958	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)	10,144	54,842	3,384	10,624,523	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B Part II | Date/Time Prepared: 9/3/2019 3:51 pm

		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
5.01	00570	ADMITTING			5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL			5.03
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,335,512		30.00
31.00	03100	INTENSIVE CARE UNIT	472,918		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	739,678		31.01
40.00	04000	SUBPROVIDER - IPF	0		40.00
43.00	04300	NURSERY	246,902		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	3,147,290		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,600		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	647,075		54.00
54.01	05401	ULTRA SOUND	3,204		54.01
56.00	05600	RADIOISOTOPE	2,399		56.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MRI	117,593		58.00
60.00	06000	LABORATORY	157,624		60.00
65.00	06500	RESPIRATORY THERAPY	11,033		65.00
66.00	06600	PHYSICAL THERAPY	42,571		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1,134		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,698		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	135,238		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,427		73.00
74.00	07400	RENAL DIALYSIS	824		74.00
76.00	03950	SLEEP LAB	151,747		76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0		76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	3,175		90.00
91.00	09100	EMERGENCY	555,659		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,856,301		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37,852		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	128,412		192.00
194.00	07950	MARKETING	0		194.00
194.01	07951	PHYSICIAN RELATIONS	0		194.01
194.02	07952	SENIOR CIRCLE	0		194.02
194.03	07953	WOMENS RESOURCE CENTER	601,958		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)	10,624,523		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B-1 | Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	224,973					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		224,973				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	576	576	36,300,434			4.00
5.01	00570	ADMITTING	0	0	2,153,789	711,092,285		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	711,092,285	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	7,561	7,561	2,458,863	0	0	5.03
7.00	00700	OPERATION OF PLANT	62,283	62,283	876,671	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	698	698	515,136	0	0	9.00
10.00	01000	DIETARY	5,709	5,709	730,667	0	0	10.00
11.00	01100	CAFETERIA	0	0	453,792	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,189	1,189	2,152,256	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,116	2,116	417,049	0	0	14.00
15.00	01500	PHARMACY	0	0	1,684,450	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	746	746	289,818	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	581,229	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,105	46,105	4,251,259	45,875,700	45,875,700	30.00
31.00	03100	INTENSIVE CARE UNIT	6,742	6,742	1,047,434	2,936,369	2,936,369	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	9,727	9,727	2,471,024	28,413,389	28,413,389	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	3,058	3,058	1,024,481	7,227,294	7,227,294	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,142	45,142	5,313,426	231,791,426	231,791,426	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	2,222,761	15,680,668	15,680,668	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,319	9,319	1,869,495	43,476,003	43,476,003	54.00
54.01	05401	ULTRA SOUND	0	0	379,551	8,976,492	8,976,492	54.01
56.00	05600	RADIOISOTOPE	0	0	101,624	4,622,084	4,622,084	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	1,724	1,724	191,125	7,405,173	7,405,173	58.00
60.00	06000	LABORATORY	1,970	1,970	1,598,282	52,078,653	52,078,653	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	979,137	8,662,661	8,662,661	65.00
66.00	06600	PHYSICAL THERAPY	598	598	335,849	2,545,872	2,545,872	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	16,218	9,100,461	9,100,461	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	55,075,948	55,075,948	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	68,902,478	68,902,478	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	83,213,280	83,213,280	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	849,190	849,190	74.00
76.00	03950	SLEEP LAB	2,236	2,236	172,315	2,198,869	2,198,869	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	331,845	2,706,505	2,706,505	90.00
91.00	09100	EMERGENCY	7,973	7,973	1,128,644	29,353,770	29,353,770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	215,472	215,472	35,748,190	711,092,285	711,092,285	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	565	565	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	733	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	8,936	8,936	551,511	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)	3,904,120	6,720,403	4,743,316	2,717,322	1,542,224	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.353727	29.872042	0.130668	0.003821	0.002169	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			27,202	1,613	0	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B-1 | Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000749	0.000002	0.000000	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: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B-1 | Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.03	5.03	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-20,954,358	87,492,823				5.03
7.00	00700	OPERATION OF PLANT	0	7,745,387	154,553			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	471,780	0	514,787		8.00
9.00	00900	HOUSEKEEPING	0	1,123,904	698	0	153,855	9.00
10.00	01000	DIETARY	0	1,598,667	5,709	0	5,709	10.00
11.00	01100	CAFETERIA	0	640,184	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,731,845	1,189	0	1,189	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,949,972	2,116	929	2,116	14.00
15.00	01500	PHARMACY	0	1,983,526	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,151,291	746	0	746	16.00
17.00	01700	SOCIAL SERVICE	0	703,135	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	8,363,473	46,105	164,292	46,105	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,929,574	6,742	26,991	6,742	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	4,025,306	9,727	9,537	9,727	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	1,655,058	3,058	7,386	3,058	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,410,516	45,142	115,450	45,142	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,858,666	0	89,238	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,468,042	9,319	42,075	9,319	54.00
54.01	05401	ULTRA SOUND	0	519,232	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	276,410	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	375,838	1,724	0	1,724	58.00
60.00	06000	LABORATORY	0	3,419,974	1,970	0	1,970	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,640,500	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	475,732	598	0	598	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	97,673	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,411,100	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,759,686	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,804,945	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	184,560	0	0	0	74.00
76.00	03950	SLEEP LAB	0	358,308	2,236	8,472	2,236	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	503,410	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,713,791	7,973	50,417	7,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-20,954,358	86,351,485	145,052	514,787	144,354	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,683	565	0	565	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,577	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	1,099,078	8,936	0	8,936	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)		20,954,358	9,600,392	584,770	1,436,435	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.239498	62.117151	1.135946	9.336291	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		358,917	2,973,789	1,935	51,390	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.004102	19.241225	0.003759	0.334016	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B-1 | Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.03	5.03	7.00	8.00	9.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B-1 | Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	145,729					10.00
11.00	01100	CAFETERIA	0	42,826				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,700	15,702,517			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,043	0	20,973,659		14.00
15.00	01500	PHARMACY	0	1,624	0	88,838	4,306,497	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	684	0	2,940	0	16.00
17.00	01700	SOCIAL SERVICE	0	726	0	2,076	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	63,399	6,621	6,766,983	395,518	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,704	1,418	873,378	134,676	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	19,234	3,429	2,469,929	333,883	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	12,245	1,431	0	150,158	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,365	3,821,864	3,715,609	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,105	12,978	468,514	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,714	433,899	363,512	0	54.00
54.01	05401	ULTRA SOUND	0	510	0	6,414	0	54.01
56.00	05600	RADIOISOTOPE	0	134	0	114,113	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	277	0	19,453	0	58.00
60.00	06000	LABORATORY	0	3,004	122,899	806,136	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,481	58,192	341,910	0	65.00
66.00	06600	PHYSICAL THERAPY	0	349	0	27,483	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5	0	282	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,165,161	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,423,555	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,306,497	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0	339	56,576	30,870	0	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	390	0	86,992	0	90.00
91.00	09100	EMERGENCY	0	1,777	1,085,819	287,847	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	97,582	42,126	15,702,517	20,965,940	4,306,497	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	48,147	1	0	161	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	699	0	7,558	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)	2,389,473	793,507	3,521,101	2,588,562	2,499,631	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.396688	18.528627	0.224238	0.123420	0.580433	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	388,471	2,966	92,432	149,736	10,144	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.665708	0.069257	0.005886	0.007139	0.002356	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B-1 | Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
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: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B-1 | Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)		
			16.00	17.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	711,092,285			16.00
17.00	01700	SOCIAL SERVICE	0	20,308		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	45,875,700	10,762		30.00
31.00	03100	INTENSIVE CARE UNIT	2,936,369	631		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	28,413,389	4,978		31.01
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
43.00	04300	NURSERY	7,227,294	3,937		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	231,791,426	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,680,668	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,476,003	0		54.00
54.01	05401	ULTRA SOUND	8,976,492	0		54.01
56.00	05600	RADIOISOTOPE	4,622,084	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	7,405,173	0		58.00
60.00	06000	LABORATORY	52,078,653	0		60.00
65.00	06500	RESPIRATORY THERAPY	8,662,661	0		65.00
66.00	06600	PHYSICAL THERAPY	2,545,872	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	9,100,461	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	55,075,948	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	68,902,478	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83,213,280	0		73.00
74.00	07400	RENAL DIALYSIS	849,190	0		74.00
76.00	03950	SLEEP LAB	2,198,869	0		76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2,706,505	0		90.00
91.00	09100	EMERGENCY	29,353,770	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	711,092,285	20,308		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	MARKETING	0	0		194.00
194.01	07951	PHYSICIAN RELATIONS	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0		194.02
194.03	07953	WOMENS RESOURCE CENTER	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)	1,493,364	885,242		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.002100	43.590802		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	54,842	3,384		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000077	0.166634		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet B-1 | Date/Time Prepared: 9/3/2019 3:51 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)		
			16.00	17.00		
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: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet C Part I Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,141,399		17,141,399	0	17,141,399	30.00
31.00	03100	INTENSIVE CARE UNIT	3,220,852		3,220,852	0	3,220,852	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	6,945,853		6,945,853	0	6,945,853	31.01
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	2,710,953		2,710,953	0	2,710,953	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,175,914		23,175,914	0	23,175,914	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,795,875		3,795,875	0	3,795,875	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,296,050		5,296,050	0	5,296,050	54.00
54.01	05401	ULTRA SOUND	672,680		672,680	0	672,680	54.01
56.00	05600	RADIOISOTOPE	368,883		368,883	0	368,883	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	612,120		612,120	0	612,120	58.00
60.00	06000	LABORATORY	4,671,891		4,671,891	0	4,671,891	60.00
65.00	06500	RESPIRATORY THERAPY	2,134,277	0	2,134,277	0	2,134,277	65.00
66.00	06600	PHYSICAL THERAPY	647,602	0	647,602	0	647,602	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	140,304		140,304	0	140,304	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,371,437		3,371,437	0	3,371,437	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,130,688		16,130,688	0	16,130,688	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,630,099		8,630,099	0	8,630,099	73.00
74.00	07400	RENAL DIALYSIS	230,545		230,545	0	230,545	74.00
76.00	03950	SLEEP LAB	640,911		640,911	0	640,911	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	647,623		647,623	0	647,623	90.00
91.00	09100	EMERGENCY	4,364,284		4,364,284	0	4,364,284	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,614,694		2,614,694		2,614,694	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	108,164,934	0	108,164,934	0	108,164,934	200.00
201.00		Less Observation Beds	2,614,694		2,614,694		2,614,694	201.00
202.00		Total (see instructions)	105,550,240	0	105,550,240	0	105,550,240	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet C Part I Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,872,031		32,872,031			30.00
31.00	03100	INTENSIVE CARE UNIT	2,936,369		2,936,369			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	28,413,389		28,413,389			31.01
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	7,227,294		7,227,294			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,819,849	189,971,577	231,791,426	0.099986	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,680,668	0	15,680,668	0.242074	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,241,393	37,234,610	43,476,003	0.121815	0.000000	54.00
54.01	05401	ULTRA SOUND	1,437,017	7,539,475	8,976,492	0.074938	0.000000	54.01
56.00	05600	RADIOISOTOPE	333,118	4,288,966	4,622,084	0.079809	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	649,232	6,755,941	7,405,173	0.082661	0.000000	58.00
60.00	06000	LABORATORY	21,091,431	30,987,222	52,078,653	0.089708	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,323,698	1,338,963	8,662,661	0.246377	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,162,735	383,137	2,545,872	0.254373	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,170,347	6,930,114	9,100,461	0.015417	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,650,352	43,425,596	55,075,948	0.061214	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,452,534	40,449,944	68,902,478	0.234109	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,059,242	48,154,038	83,213,280	0.103711	0.000000	73.00
74.00	07400	RENAL DIALYSIS	776,699	72,491	849,190	0.271488	0.000000	74.00
76.00	03950	SLEEP LAB	66,199	2,132,670	2,198,869	0.291473	0.000000	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	30,820	2,675,685	2,706,505	0.239284	0.000000	90.00
91.00	09100	EMERGENCY	4,327,557	25,026,213	29,353,770	0.148679	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,218,546	11,785,123	13,003,669	0.201074	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	251,940,520	459,151,765	711,092,285			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	251,940,520	459,151,765	711,092,285			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet C Part I Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT			31.01
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.099986		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.242074		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.121815		54.00
54.01	05401	ULTRA SOUND	0.074938		54.01
56.00	05600	RADIOISOTOPE	0.079809		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.082661		58.00
60.00	06000	LABORATORY	0.089708		60.00
65.00	06500	RESPIRATORY THERAPY	0.246377		65.00
66.00	06600	PHYSICAL THERAPY	0.254373		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.015417		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.061214		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234109		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.103711		73.00
74.00	07400	RENAL DIALYSIS	0.271488		74.00
76.00	03950	SLEEP LAB	0.291473		76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.239284		90.00
91.00	09100	EMERGENCY	0.148679		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.201074		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet C Part I Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,141,399		17,141,399	0	17,141,399	30.00
31.00	03100	INTENSIVE CARE UNIT	3,220,852		3,220,852	0	3,220,852	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	6,945,853		6,945,853	0	6,945,853	31.01
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	2,710,953		2,710,953	0	2,710,953	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,175,914		23,175,914	0	23,175,914	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,795,875		3,795,875	0	3,795,875	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,296,050		5,296,050	0	5,296,050	54.00
54.01	05401	ULTRA SOUND	672,680		672,680	0	672,680	54.01
56.00	05600	RADIOISOTOPE	368,883		368,883	0	368,883	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	612,120		612,120	0	612,120	58.00
60.00	06000	LABORATORY	4,671,891		4,671,891	0	4,671,891	60.00
65.00	06500	RESPIRATORY THERAPY	2,134,277	0	2,134,277	0	2,134,277	65.00
66.00	06600	PHYSICAL THERAPY	647,602	0	647,602	0	647,602	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	140,304		140,304	0	140,304	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,371,437		3,371,437	0	3,371,437	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,130,688		16,130,688	0	16,130,688	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,630,099		8,630,099	0	8,630,099	73.00
74.00	07400	RENAL DIALYSIS	230,545		230,545	0	230,545	74.00
76.00	03950	SLEEP LAB	640,911		640,911	0	640,911	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	647,623		647,623	0	647,623	90.00
91.00	09100	EMERGENCY	4,364,284		4,364,284	0	4,364,284	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,614,694		2,614,694		2,614,694	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	108,164,934	0	108,164,934	0	108,164,934	200.00
201.00		Less Observation Beds	2,614,694		2,614,694		2,614,694	201.00
202.00		Total (see instructions)	105,550,240	0	105,550,240	0	105,550,240	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet C Part I Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,872,031		32,872,031			30.00
31.00	03100	INTENSIVE CARE UNIT	2,936,369		2,936,369			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	28,413,389		28,413,389			31.01
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	7,227,294		7,227,294			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,819,849	189,971,577	231,791,426	0.099986	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,680,668	0	15,680,668	0.242074	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,241,393	37,234,610	43,476,003	0.121815	0.000000	54.00
54.01	05401	ULTRA SOUND	1,437,017	7,539,475	8,976,492	0.074938	0.000000	54.01
56.00	05600	RADIOISOTOPE	333,118	4,288,966	4,622,084	0.079809	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	649,232	6,755,941	7,405,173	0.082661	0.000000	58.00
60.00	06000	LABORATORY	21,091,431	30,987,222	52,078,653	0.089708	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,323,698	1,338,963	8,662,661	0.246377	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,162,735	383,137	2,545,872	0.254373	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,170,347	6,930,114	9,100,461	0.015417	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,650,352	43,425,596	55,075,948	0.061214	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,452,534	40,449,944	68,902,478	0.234109	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,059,242	48,154,038	83,213,280	0.103711	0.000000	73.00
74.00	07400	RENAL DIALYSIS	776,699	72,491	849,190	0.271488	0.000000	74.00
76.00	03950	SLEEP LAB	66,199	2,132,670	2,198,869	0.291473	0.000000	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	30,820	2,675,685	2,706,505	0.239284	0.000000	90.00
91.00	09100	EMERGENCY	4,327,557	25,026,213	29,353,770	0.148679	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,218,546	11,785,123	13,003,669	0.201074	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	251,940,520	459,151,765	711,092,285			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	251,940,520	459,151,765	711,092,285			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet C Part I Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT			31.01
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.099986		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.242074		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.121815		54.00
54.01	05401	ULTRA SOUND	0.074938		54.01
56.00	05600	RADIOISOTOPE	0.079809		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.082661		58.00
60.00	06000	LABORATORY	0.089708		60.00
65.00	06500	RESPIRATORY THERAPY	0.246377		65.00
66.00	06600	PHYSICAL THERAPY	0.254373		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.015417		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.061214		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234109		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.103711		73.00
74.00	07400	RENAL DIALYSIS	0.271488		74.00
76.00	03950	SLEEP LAB	0.291473		76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.239284		90.00
91.00	09100	EMERGENCY	0.148679		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.201074		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet C Part II Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,175,914	3,147,290	20,028,624	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,795,875	18,600	3,777,275	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,296,050	647,075	4,648,975	0	0	54.00
54.01	05401	ULTRA SOUND	672,680	3,204	669,476	0	0	54.01
56.00	05600	RADIOISOTOPE	368,883	2,399	366,484	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	612,120	117,593	494,527	0	0	58.00
60.00	06000	LABORATORY	4,671,891	157,624	4,514,267	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,134,277	11,033	2,123,244	0	0	65.00
66.00	06600	PHYSICAL THERAPY	647,602	42,571	605,031	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	140,304	1,134	139,170	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,371,437	29,698	3,341,739	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,130,688	135,238	15,995,450	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,630,099	36,427	8,593,672	0	0	73.00
74.00	07400	RENAL DIALYSIS	230,545	824	229,721	0	0	74.00
76.00	03950	SLEEP LAB	640,911	151,747	489,164	0	0	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	647,623	3,175	644,448	0	0	90.00
91.00	09100	EMERGENCY	4,364,284	555,659	3,808,625	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,614,694	508,788	2,105,906	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	78,145,877	5,570,079	72,575,798	0	0	200.00
201.00		Less Observation Beds	2,614,694	508,788	2,105,906	0	0	201.00
202.00		Total (line 200 minus line 201)	75,531,183	5,061,291	70,469,892	0	0	202.00

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

Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet C Part II Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	23,175,914	231,791,426	0.099986		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,795,875	15,680,668	0.242074		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,296,050	43,476,003	0.121815		54.00
54.01	05401	ULTRA SOUND	672,680	8,976,492	0.074938		54.01
56.00	05600	RADIOISOTOPE	368,883	4,622,084	0.079809		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	612,120	7,405,173	0.082661		58.00
60.00	06000	LABORATORY	4,671,891	52,078,653	0.089708		60.00
65.00	06500	RESPIRATORY THERAPY	2,134,277	8,662,661	0.246377		65.00
66.00	06600	PHYSICAL THERAPY	647,602	2,545,872	0.254373		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	140,304	9,100,461	0.015417		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,371,437	55,075,948	0.061214		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,130,688	68,902,478	0.234109		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,630,099	83,213,280	0.103711		73.00
74.00	07400	RENAL DIALYSIS	230,545	849,190	0.271488		74.00
76.00	03950	SLEEP LAB	640,911	2,198,869	0.291473		76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	647,623	2,706,505	0.239284		90.00
91.00	09100	EMERGENCY	4,364,284	29,353,770	0.148679		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,614,694	13,003,669	0.201074		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
200.00		Subtotal (sum of lines 50 thru 199)	78,145,877	639,643,202			200.00
201.00		Less Observation Beds	2,614,694	0			201.00
202.00		Total (line 200 minus line 201)	75,531,183	639,643,202			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D Part I Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,335,512	0	3,335,512	12,574	265.27	30.00
31.00	INTENSIVE CARE UNIT	472,918		472,918	631	749.47	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	739,678		739,678	4,978	148.59	31.01
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
43.00	NURSERY	246,902		246,902	3,937	62.71	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	4,795,010		4,795,010	22,120		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	1,821	483,057	30.00
31.00	INTENSIVE CARE UNIT	191	143,149	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	0	0	31.01
40.00	SUBPROVIDER - IPF	0	0	40.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	2,012	626,206	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D Part II Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,147,290	231,791,426	0.013578	5,677,440	77,088	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,600	15,680,668	0.001186	17,878	21	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	647,075	43,476,003	0.014883	1,985,077	29,544	54.00
54.01	05401	ULTRA SOUND	3,204	8,976,492	0.000357	257,061	92	54.01
56.00	05600	RADIOISOTOPE	2,399	4,622,084	0.000519	130,510	68	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	117,593	7,405,173	0.015880	182,463	2,898	58.00
60.00	06000	LABORATORY	157,624	52,078,653	0.003027	3,894,214	11,788	60.00
65.00	06500	RESPIRATORY THERAPY	11,033	8,662,661	0.001274	1,262,260	1,608	65.00
66.00	06600	PHYSICAL THERAPY	42,571	2,545,872	0.016722	560,226	9,368	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,134	9,100,461	0.000125	662,254	83	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,698	55,075,948	0.000539	2,571,117	1,386	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	135,238	68,902,478	0.001963	5,534,199	10,864	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,427	83,213,280	0.000438	6,692,949	2,932	73.00
74.00	07400	RENAL DIALYSIS	824	849,190	0.000970	381,363	370	74.00
76.00	03950	SLEEP LAB	151,747	2,198,869	0.069011	19,840	1,369	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,175	2,706,505	0.001173	826	1	90.00
91.00	09100	EMERGENCY	555,659	29,353,770	0.018930	1,304,544	24,695	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	508,788	13,003,669	0.039126	435,387	17,035	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	5,570,079	639,643,202		31,569,608	191,210	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D Part III Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	12,574	0.00	1,821	30.00
31.00	03100	INTENSIVE CARE UNIT		0	631	0.00	191	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0	4,978	0.00	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
43.00	04300	NURSERY		0	3,937	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	22,120		2,012	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D Part IV Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0	0	0	0	0	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D Part IV Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	231,791,426	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	15,680,668	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	43,476,003	0.000000	54.00
54.01	05401	ULTRA SOUND	0	0	0	8,976,492	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	4,622,084	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	7,405,173	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	52,078,653	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,662,661	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,545,872	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	9,100,461	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	55,075,948	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	68,902,478	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	83,213,280	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	849,190	0.000000	74.00
76.00	03950	SLEEP LAB	0	0	0	2,198,869	0.000000	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	2,706,505	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	29,353,770	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,003,669	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	639,643,202		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D Part IV Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	5,677,440	0	35,092,645	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	17,878	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,985,077	0	6,520,486	0	54.00
54.01	05401	ULTRA SOUND	0.000000	257,061	0	901,630	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	130,510	0	1,114,585	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	182,463	0	1,130,217	0	58.00
60.00	06000	LABORATORY	0.000000	3,894,214	0	2,882,458	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,262,260	0	170,226	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	560,226	0	26,329	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	662,254	0	1,485,258	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,571,117	0	10,403,324	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,534,199	0	10,014,761	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,692,949	0	10,895,465	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	381,363	0	28,544	0	74.00
76.00	03950	SLEEP LAB	0.000000	19,840	0	287,794	0	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	826	0	438,982	0	90.00
91.00	09100	EMERGENCY	0.000000	1,304,544	0	2,739,931	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	435,387	0	785,829	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		31,569,608	0	84,918,464	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D Part V Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.099986	35,092,645	0	0	3,508,773	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.242074	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.121815	6,520,486	0	0	794,293	54.00
54.01	05401	ULTRA SOUND	0.074938	901,630	0	0	67,566	54.01
56.00	05600	RADIOISOTOPE	0.079809	1,114,585	0	0	88,954	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.082661	1,130,217	0	0	93,425	58.00
60.00	06000	LABORATORY	0.089708	2,882,458	0	0	258,580	60.00
65.00	06500	RESPIRATORY THERAPY	0.246377	170,226	0	0	41,940	65.00
66.00	06600	PHYSICAL THERAPY	0.254373	26,329	0	0	6,697	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.015417	1,485,258	0	0	22,898	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.061214	10,403,324	0	0	636,829	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234109	10,014,761	0	0	2,344,546	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.103711	10,895,465	0	12,146	1,129,980	73.00
74.00	07400	RENAL DIALYSIS	0.271488	28,544	0	0	7,749	74.00
76.00	03950	SLEEP LAB	0.291473	287,794	0	0	83,884	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.239284	438,982	0	0	105,041	90.00
91.00	09100	EMERGENCY	0.148679	2,739,931	0	0	407,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.201074	785,829	0	0	158,010	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		84,918,464	0	12,146	9,756,535	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		84,918,464	0	12,146	9,756,535	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D Part V Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,260		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	SLEEP LAB	0	0		76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,260		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,260		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D Part I Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,335,512	0	3,335,512	12,574	265.27	30.00
31.00	INTENSIVE CARE UNIT	472,918		472,918	631	749.47	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	739,678		739,678	4,978	148.59	31.01
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
43.00	NURSERY	246,902		246,902	3,937	62.71	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	4,795,010		4,795,010	22,120		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	250	66,318	30.00
31.00	INTENSIVE CARE UNIT	12	8,994	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	115	17,088	31.01
40.00	SUBPROVIDER - IPF	0	0	40.00
43.00	NURSERY	2,137	134,011	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	2,514	226,411	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D Part II Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,147,290	231,791,426	0.013578	387,244	5,258	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,600	15,680,668	0.001186	256,798	305	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	647,075	43,476,003	0.014883	104,120	1,550	54.00
54.01	05401	ULTRA SOUND	3,204	8,976,492	0.000357	28,220	10	54.01
56.00	05600	RADIOISOTOPE	2,399	4,622,084	0.000519	2,965	2	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	117,593	7,405,173	0.015880	19,068	303	58.00
60.00	06000	LABORATORY	157,624	52,078,653	0.003027	494,749	1,498	60.00
65.00	06500	RESPIRATORY THERAPY	11,033	8,662,661	0.001274	178,762	228	65.00
66.00	06600	PHYSICAL THERAPY	42,571	2,545,872	0.016722	44,634	746	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,134	9,100,461	0.000125	44,479	6	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,698	55,075,948	0.000539	306,352	165	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	135,238	68,902,478	0.001963	453,182	890	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,427	83,213,280	0.000438	711,282	312	73.00
74.00	07400	RENAL DIALYSIS	824	849,190	0.000970	24,266	24	74.00
76.00	03950	SLEEP LAB	151,747	2,198,869	0.069011	1,550	107	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,175	2,706,505	0.001173	1,008	1	90.00
91.00	09100	EMERGENCY	555,659	29,353,770	0.018930	113,778	2,154	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	508,788	13,003,669	0.039126	24,371	954	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	5,570,079	639,643,202		3,196,828	14,513	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D Part III Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	12,574	0.00	250	30.00
31.00	03100	INTENSIVE CARE UNIT		0	631	0.00	12	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0	4,978	0.00	115	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
43.00	04300	NURSERY		0	3,937	0.00	2,137	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	22,120		2,514	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D Part IV Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0	0	0	0	0	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D Part IV Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | 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	231,791,426	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	15,680,668	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	43,476,003	0.000000	54.00
54.01	05401	ULTRA SOUND	0	0	0	8,976,492	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	4,622,084	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	7,405,173	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	52,078,653	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,662,661	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,545,872	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	9,100,461	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	55,075,948	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	68,902,478	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	83,213,280	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	849,190	0.000000	74.00
76.00	03950	SLEEP LAB	0	0	0	2,198,869	0.000000	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0	0	0	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	2,706,505	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	29,353,770	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,003,669	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	639,643,202		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D Part IV Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	387,244	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	256,798	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	104,120	0	0	0	54.00
54.01	05401	ULTRA SOUND	0.000000	28,220	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	2,965	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	19,068	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	494,749	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	178,762	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	44,634	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	44,479	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	306,352	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	453,182	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	711,282	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	24,266	0	0	0	74.00
76.00	03950	SLEEP LAB	0.000000	1,550	0	0	0	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	1,008	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	113,778	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	24,371	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		3,196,828	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D Part V Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.099986	0	0	800,271	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.242074	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.121815	0	0	392,513	0	54.00
54.01	05401	ULTRA SOUND	0.074938	0	0	90,987	0	54.01
56.00	05600	RADIOISOTOPE	0.079809	0	0	20,438	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.082661	0	0	33,188	0	58.00
60.00	06000	LABORATORY	0.089708	0	0	346,396	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.246377	0	0	16,524	0	65.00
66.00	06600	PHYSICAL THERAPY	0.254373	0	0	6,986	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.015417	0	0	77,612	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.061214	0	0	96,853	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234109	0	0	130,740	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.103711	0	0	248,063	0	73.00
74.00	07400	RENAL DIALYSIS	0.271488	0	0	3,467	0	74.00
76.00	03950	SLEEP LAB	0.291473	0	0	29,680	0	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.239284	0	0	20,011	0	90.00
91.00	09100	EMERGENCY	0.148679	0	0	555,759	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.201074	0	0	118,686	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	0	2,988,174	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	2,988,174	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D Part V Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	80,016		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,814		54.00
54.01	05401	ULTRA SOUND	0	6,818		54.01
56.00	05600	RADIOISOTOPE	0	1,631		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	2,743		58.00
60.00	06000	LABORATORY	0	31,074		60.00
65.00	06500	RESPIRATORY THERAPY	0	4,071		65.00
66.00	06600	PHYSICAL THERAPY	0	1,777		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,197		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,929		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30,607		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,727		73.00
74.00	07400	RENAL DIALYSIS	0	941		74.00
76.00	03950	SLEEP LAB	0	8,651		76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	4,788		90.00
91.00	09100	EMERGENCY	0	82,630		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	23,865		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	360,279		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	360,279		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D-1 | Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,574	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,574	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)	10,656	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)	1,821	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)	17,141,399	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)	17,141,399	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)	17,141,399	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)	1,363.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,482,460	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)	2,482,460	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D-1 | Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,220,852	631	5,104.36	191	974,933	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	6,945,853	4,978	1,395.31	0	0	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,209,763	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,667,156	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)	626,206	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	191,210	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	817,416	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,849,740	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)	1,918	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,363.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,614,694	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D-1 | Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,335,512	17,141,399	0.194588	2,614,694	508,788	90.00
91.00	Nursing School cost	0	17,141,399	0.000000	2,614,694	0	91.00
92.00	Allied health cost	0	17,141,399	0.000000	2,614,694	0	92.00
93.00	All other Medical Education	0	17,141,399	0.000000	2,614,694	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D-1 | Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,574	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,574	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)	10,656	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)	250	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)	3,937	15.00
16.00	Nursery days (title V or XIX only)	2,137	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)	17,141,399	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)	17,141,399	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)	17,141,399	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)	1,363.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	340,810	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)	340,810	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D-1 | Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2,710,953	3,937	688.58	2,137	1,471,495	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,220,852	631	5,104.36	12	61,252	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	6,945,853	4,978	1,395.31	115	160,461	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	445,672	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,479,690	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)	226,411	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	14,513	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	240,924	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,238,766	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,918	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,363.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,614,694	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D-1 | Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,335,512	17,141,399	0.194588	2,614,694	508,788	90.00
91.00	Nursing School cost	0	17,141,399	0.000000	2,614,694	0	91.00
92.00	Allied health cost	0	17,141,399	0.000000	2,614,694	0	92.00
93.00	All other Medical Education	0	17,141,399	0.000000	2,614,694	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D-3 | Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,285,014		30.00
31.00	03100	INTENSIVE CARE UNIT		960,626		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0		31.01
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.099986	5,677,440	567,665	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.242074	17,878	4,328	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.121815	1,985,077	241,812	54.00
54.01	05401	ULTRA SOUND	0.074938	257,061	19,264	54.01
56.00	05600	RADIOISOTOPE	0.079809	130,510	10,416	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.082661	182,463	15,083	58.00
60.00	06000	LABORATORY	0.089708	3,894,214	349,342	60.00
65.00	06500	RESPIRATORY THERAPY	0.246377	1,262,260	310,992	65.00
66.00	06600	PHYSICAL THERAPY	0.254373	560,226	142,506	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.015417	662,254	10,210	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.061214	2,571,117	157,388	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234109	5,534,199	1,295,606	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.103711	6,692,949	694,132	73.00
74.00	07400	RENAL DIALYSIS	0.271488	381,363	103,535	74.00
76.00	03950	SLEEP LAB	0.291473	19,840	5,783	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.239284	826	198	90.00
91.00	09100	EMERGENCY	0.148679	1,304,544	193,958	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.201074	435,387	87,545	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		31,569,608	4,209,763	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)		31,569,608		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet D-3 | Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		555,887		30.00
31.00	03100	INTENSIVE CARE UNIT		34,918		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		1,267,824		31.01
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		238,291		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.099986	387,244	38,719	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.242074	256,798	62,164	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.121815	104,120	12,683	54.00
54.01	05401	ULTRA SOUND	0.074938	28,220	2,115	54.01
56.00	05600	RADIOISOTOPE	0.079809	2,965	237	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.082661	19,068	1,576	58.00
60.00	06000	LABORATORY	0.089708	494,749	44,383	60.00
65.00	06500	RESPIRATORY THERAPY	0.246377	178,762	44,043	65.00
66.00	06600	PHYSICAL THERAPY	0.254373	44,634	11,354	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.015417	44,479	686	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.061214	306,352	18,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234109	453,182	106,094	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.103711	711,282	73,768	73.00
74.00	07400	RENAL DIALYSIS	0.271488	24,266	6,588	74.00
76.00	03950	SLEEP LAB	0.291473	1,550	452	76.00
76.02	03560	PSYCH SERVICES/EATINT DISORDER	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.239284	1,008	241	90.00
91.00	09100	EMERGENCY	0.148679	113,778	16,916	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.201074	24,371	4,900	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,196,828	445,672	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)		3,196,828		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0150	Period: From 04/01/2018 To 03/31/2019	Worksheet E Part A Date/Time Prepared: 9/3/2019 3:51 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,095,967	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,012,743	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)	489,206	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	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	125.75	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)	3.59	30.00
31.00	Percentage of Medicaid patient days (see instructions)	32.49	31.00
32.00	Sum of lines 30 and 31	36.08	32.00
33.00	Allowable disproportionate share percentage (see instructions)	18.98	33.00
34.00	Disproportionate share adjustment (see instructions)	194,959	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet E Part A Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,007,408	787,039	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	505,084	392,441	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	897,525		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)	5,690,400		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)		5,690,400	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		436,428	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		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see 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)		6,126,828	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,126,828	61.00
62.00	Deductibles billed to program beneficiaries		519,184	62.00
63.00	Coinsurance billed to program beneficiaries		7,071	63.00
64.00	Allowable bad debts (see instructions)		50,626	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		32,907	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		10,218	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		5,633,480	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)		-12,470	70.93
70.94	HRR adjustment amount (see instructions)		-3,254	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet E Part A Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,617,756	71.00
71.01	Sequestration adjustment (see instructions)		112,355	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		5,330,143	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)		175,258	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		413,848	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,095,967	2,095,967		2,095,967	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,012,743		2,012,743	2,012,743	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	489,206	185,048	304,158	489,206	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1898	0.1898	0.1898		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	194,959	99,454	95,505	194,959	11.00
11.01	Uncompensated care payments	36.00	897,525	505,084	392,441	897,525	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	5,690,400	2,885,553	2,804,847	5,690,400	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,690,400	2,885,553	2,804,847	5,690,400	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	436,428	265,624	170,804	436,428	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			3,151,177	2,975,651	6,126,828	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	330,117	168,447	161,670	330,117	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	81,288	84,409	-3,121	81,288	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0758	0.0758	0.0758		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	25,023	12,768	12,255	25,023	25.00
26.00	Total prospective capital payments (see instructions)	12.00	436,428	265,624	170,804	436,428	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-12,470	-16,774	4,304	-12,470	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-3,254	-839	-2,415	-3,254	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0150	Period: From 04/01/2018 To 03/31/2019	Worksheet E Part B Date/Time Prepared: 9/3/2019 3:51 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,260	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	9,756,535	2.00
3.00	OPPS payments	8,408,382	3.00
4.00	Outlier payment (see instructions)	118,367	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)	1,260	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	12,146	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)	12,146	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)	12,146	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	10,886	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)	1,260	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)	8,526,749	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	7,385	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,470,266	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)	7,050,358	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)	7,050,358	30.00
31.00	Primary payer payments	1,256	31.00
32.00	Subtotal (line 30 minus line 31)	7,049,102	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)	188,459	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	122,498	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	138,343	36.00
37.00	Subtotal (see instructions)	7,171,600	37.00
38.00	MSP-LCC reconciliation amount from PS&R	30	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)	7,171,570	40.00
40.01	Sequestration adjustment (see instructions)	143,431	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	7,031,111	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-2,972	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: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 9/3/2019 3:51 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,330,143		6,907,305	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		123,806	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)		5,330,143		7,031,111	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		175,258		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		2,972	6.02
7.00	Total Medicare program liability (see instructions)		5,505,401		7,028,139	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: 15-0150	Period: From 04/01/2018 To 03/31/2019	Worksheet E-1 Part II Date/Time Prepared: 9/3/2019 3:51 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet E-3 Part VII | Date/Time Prepared: 9/3/2019 3:51 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		360,279	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	360,279	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	360,279	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	3,264,439		8.00
9.00	Ancillary service charges	3,196,828	2,988,174	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)	6,461,267	2,988,174	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)	6,461,267	2,988,174	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	6,461,267	2,627,895	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	360,279	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	360,279	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	360,279	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	360,279	36.00
37.00	ELIMINATE SETTLEMENT	0	-360,279	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet G | Date/Time Prepared: 9/3/2019 3:51 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	352,928	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	40,705,392	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,280,744	0	0	0	6.00
7.00	Inventory	3,753,298	0	0	0	7.00
8.00	Prepaid expenses	1,553,612	0	0	0	8.00
9.00	Other current assets	-600,640	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	42,483,846	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,060,000	0	0	0	12.00
13.00	Land improvements	629,378	0	0	0	13.00
14.00	Accumulated depreciation	-409,436	0	0	0	14.00
15.00	Buildings	63,596,706	0	0	0	15.00
16.00	Accumulated depreciation	-15,018,093	0	0	0	16.00
17.00	Leasehold improvements	10,382,498	0	0	0	17.00
18.00	Accumulated depreciation	-1,092,176	0	0	0	18.00
19.00	Fixed equipment	2,329,546	0	0	0	19.00
20.00	Accumulated depreciation	-2,534,461	0	0	0	20.00
21.00	Automobiles and trucks	24,168	0	0	0	21.00
22.00	Accumulated depreciation	-13,091	0	0	0	22.00
23.00	Major movable equipment	42,591,650	0	0	0	23.00
24.00	Accumulated depreciation	-29,436,711	0	0	0	24.00
25.00	Minor equipment depreciable	8,195,241	0	0	0	25.00
26.00	Accumulated depreciation	-6,241,535	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	74,063,684	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	5,944,505	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,944,505	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	122,492,035	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,563,214	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,004,087	0	0	0	38.00
39.00	Payroll taxes payable	390,550	0	0	0	39.00
40.00	Notes and loans payable (short term)	792,704	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	-336,313,168	0	0	0	43.00
44.00	Other current liabilities	1,640,690	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-324,921,923	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	711,440	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	48,609,279	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	49,320,719	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-275,601,204	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	398,093,239				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)	398,093,239	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	122,492,035	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet G-1 | Date/Time Prepared: 9/3/2019 3:51 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		367,646,755		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		30,444,732				2.00
3.00	Total (sum of line 1 and line 2)		398,091,487		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)		398,091,487		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		398,091,487		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2018 To 03/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/3/2019 3:51 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	40,099,325		40,099,325	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	40,099,325		40,099,325	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,936,369		2,936,369	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	28,413,389		28,413,389	11.01
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	31,349,758		31,349,758	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	71,449,083		71,449,083	17.00
18.00	Ancillary services	174,914,514	419,664,744	594,579,258	18.00
19.00	Outpatient services	5,576,923	39,487,021	45,063,944	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	251,940,520	459,151,765	711,092,285	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		126,813,953		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		126,813,953		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0150	Period: From 04/01/2018 To 03/31/2019	Worksheet G-3 Date/Time Prepared: 9/3/2019 3:51 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	711,092,285	1.00
2.00	Less contractual allowances and discounts on patients' accounts	554,901,133	2.00
3.00	Net patient revenues (line 1 minus line 2)	156,191,152	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	126,813,953	4.00
5.00	Net income from service to patients (line 3 minus line 4)	29,377,199	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISCELLANEOUS REVENUE	1,067,533	24.00
25.00	Total other income (sum of lines 6-24)	1,067,533	25.00
26.00	Total (line 5 plus line 25)	30,444,732	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)	30,444,732	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0150	Period: From 04/01/2018 To 03/31/2019	Worksheet L Parts I-III Date/Time Prepared: 9/3/2019 3:51 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	330,117	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	81,288	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)	47.15	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)	3.59	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	32.49	8.00
9.00	Sum of lines 7 and 8	36.08	9.00
10.00	Allowable disproportionate share percentage (see instructions)	7.58	10.00
11.00	Disproportionate share adjustment (see instructions)	25,023	11.00
12.00	Total prospective capital payments (see instructions)	436,428	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