

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: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 3:00 pm
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**PART I - COST REPORT STATUS**

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

Date: 5/29/2019 Time: 3:00 pm

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

**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 COMMUNITY HOSPITAL SOUTH ( 15-0128 ) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) HOLLY MILLARD  
 Officer or Administrator of Provider(s)

NETWORK SENIOR VICE PRESIDENT OF FIN  
 Title

(Dated when report is electronically signed.)  
 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	640,098	40,213	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	0		0	6.00
200.00 Total	0	640,098	40,213	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: 15-0128		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:00 pm				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1402 EAST COUNTY LINE ROAD SOUTH	PO Box:	Zip Code: 46227		County: MARION				1.00	
2.00	City: INDIANAPOLIS	State: IN							2.00	
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
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	COMMUNITY HOSPITAL SOUTH	150128	26900	1	07/01/1966	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)				01/01/2018		12/31/2018		20.00	
21.00	Type of Control (see instructions)				2				21.00	
					1.00		2.00		3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.			Y	N				22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			Y	Y				22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.			N	N				22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.			N	N	N			22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.			3	N				23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	888	310	0	45	8,085	17		24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:00 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	0	25.00	
						Urban/Rural	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					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 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVII	XIX	
						1.00	2.00	3.00	
<u>Prospective Payment System (PPS)-Capital</u>									
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
<u>Teaching Hospitals</u>									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N		60.00	

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	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		
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>							
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
<b>Teaching Hospitals that Claim Residents in Nonprovider Settings</b>							
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		
64.00	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. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
			1.00	2.00	3.00			
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	2.13	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)	FAMILY MEDICINE	1350	0.00	5.08	0.000000		67.00
					1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			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

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						1.00			
<b>Long Term Care Hospital PPS</b>									
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	
<b>TEFRA Providers</b>									
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		
<b>Title V and XIX Services</b>									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.					N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.					N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? 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	
<b>Rural Providers</b>									
105.00	Does this hospital qualify as a CAH?					N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)							106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.							107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					N		108.00	
						Physical	Occupational	Speech	Respiratory
						1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.								109.00
						1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.					N			110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:00 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	
<b>Miscellaneous Cost Reporting Information</b>					
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:	589,337	0		118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
<b>Transplant Center Information</b>					
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
<b>All Providers</b>					
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		HB0720	140.00





HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0128		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 3:00 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				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/29/2014	Y	04/29/2014		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: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 3:00 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
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
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
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
					Y/N
					Date
					1.00
					2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
					1.00
					2.00
<b>Cost Report Preparer Contact Information</b>					
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.	RONALD		HELMS	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH NETWORK			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-5501		RHELMS@COMMUNITY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 3:00 pm
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0128

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2019 3:00 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	157	57,305	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)		157	57,305	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		169	61,685	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		169				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: 15-0128

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2019 3:00 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)	12,279	811	33,892			1.00
2.00	HMO and other (see instructions)	5,643	6,967				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	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	12,279	811	33,892			7.00
8.00	INTENSIVE CARE UNIT	945	0	2,888			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1,550	3,184			13.00
14.00	Total (see instructions)	13,224	2,361	39,964	7.87	877.40	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			527			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)				7.87	877.40	27.00
28.00	Observation Bed Days		931	4,532			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			496			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	17	623			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: 15-0128

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2019 3:00 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	3,315	146	9,954	1.00
2.00 HMO and other (see instructions)			1,251	1,605		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
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	3,315	146	9,954	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0128

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/29/2019 3:00 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	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	61,704,432	-349,182	61,355,250	1,824,988.00	33.62
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		401,766	0	401,766	1,940.00	207.10
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		254,193	0	254,193	4,160.00	61.10
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		429,538	0	429,538	17,344.00	24.77
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		529,772	0	529,772	6,101.00	86.83
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		1,689,538	0	1,689,538	19,876.00	85.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		19,232,360	0	19,232,360	443,427.00	43.37
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		15,013,367	0	15,013,367		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		133,543	0	133,543		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		20,055	0	20,055		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		42,819	0	42,819		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		441,224	0	441,224		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	5,629	0	5,629	143.00	39.36
27.00	Administrative & General	5.00	4,128,200	-11,643	4,116,557	87,444.00	47.08

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0128

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/29/2019 3:00 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.)	5,471,408	0	5,471,408	59,698.00	91.65	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	1,533,473	-13,702	1,519,771	67,085.00	22.65	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	1,266,156	-5,071	1,261,085	83,743.00	15.06	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	1,223,272	-844,424	378,848	22,421.00	16.90	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	840,809	840,809	49,290.00	17.06	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	266,287	-319	265,968	17,333.00	15.34	38.00
39.00	Central Services and Supply	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	253,780	-287	253,493	6,222.00	40.74	41.00
42.00	Social Service	1,247,685	-8,737	1,238,948	33,047.00	37.49	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00



HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0128

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/29/2019 3:00 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	66,921,647	-349,182	66,572,465	1,880,526.00	35.40	1.00
2.00	Excluded area salaries (see instructions)	429,538	0	429,538	17,344.00	24.77	2.00
3.00	Subtotal salaries (line 1 minus line 2)	66,492,109	-349,182	66,142,927	1,863,182.00	35.50	3.00
4.00	Subtotal other wages & related costs (see inst.)	21,451,670	0	21,451,670	469,404.00	45.70	4.00
5.00	Subtotal wage-related costs (see inst.)	15,474,646	0	15,474,646	0.00	23.40	5.00
6.00	Total (sum of lines 3 thru 5)	103,418,425	-349,182	103,069,243	2,332,586.00	44.19	6.00
7.00	Total overhead cost (see instructions)	15,395,890	-43,374	15,352,516	426,426.00	36.00	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2019 3:00 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			1,937,121 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
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		252,151	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
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)		6,102,239	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		1,745,305	9.00
10.00	Dental, Hearing and Vision Plan		65,259	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		35,441	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		519,061	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		100,700	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
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		4,383,553	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
<b>OTHER</b>				
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		68,953	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		15,209,783	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part V Date/Time Prepared: 5/29/2019 3:00 pm
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	529,772	15,209,783	1.00
2.00	Hospital	529,772	15,013,367	2.00
3.00	Subprovider - IPF			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			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	196,416	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/29/2019 3:00 pm
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.203454	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,014,857	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		159,334,768	6.00	
7.00	Medicaid cost (line 1 times line 6)		32,417,296	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)		30,402,439	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		30,402,439	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)	18,512,319	1,757,554	20,269,873	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,766,405	1,757,554	5,523,959	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	3,766,405	1,757,554	5,523,959	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)			1,241,296	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			301,385	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			463,668	27.01
28.00	Non-Medicare bad debt expense (see instructions)			777,628	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			320,495	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			5,844,454	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			36,246,893	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0128

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

Worksheet A  
Date/Time Prepared:  
5/29/2019 3:00 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	9,557,912	9,557,912	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	6,125,630	6,125,630	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,629	6,042	11,671	-71	11,600
5.00	00500	ADMINISTRATIVE & GENERAL	4,128,200	67,991,186	72,119,386	-8,713,781	63,405,605
7.00	00700	OPERATION OF PLANT	1,533,473	3,798,162	5,331,635	143,019	5,474,654
8.00	00800	LAUNDRY & LINEN SERVICE	0	696,382	696,382	-613	695,769
9.00	00900	HOUSEKEEPING	1,266,156	936,610	2,202,766	-18,801	2,183,965
10.00	01000	DIETARY	1,223,272	1,802,885	3,026,157	-2,012,682	1,013,475
11.00	01100	CAFETERIA	0	0	1,939,854	1,939,854	11.00
13.00	01300	NURSING ADMINISTRATION	266,287	50,098	316,385	0	316,385
16.00	01600	MEDICAL RECORDS & LIBRARY	253,780	57,266	311,046	-80	310,966
17.00	01700	SOCIAL SERVICE	1,247,685	328,648	1,576,333	-2,276	1,574,057
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	21,897,972	8,890,068	30,788,040	-4,967,062	25,820,978
31.00	03100	INTENSIVE CARE UNIT	2,677,648	1,234,004	3,911,652	-394,862	3,516,790
43.00	04300	NURSERY	0	0	0	947,054	947,054
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,241,744	16,676,222	19,917,966	-13,876,986	6,040,980
51.00	05100	RECOVERY ROOM	2,588,380	1,141,322	3,729,702	-219,450	3,510,252
52.00	05200	DELIVERY ROOM & LABOR ROOM	573,726	66,072	639,798	2,462,598	3,102,396
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,695,970	1,938,240	3,634,210	-1,233,071	2,401,139
55.00	05500	RADIOLOGY-THERAPEUTIC	556,506	1,326,660	1,883,166	-874,138	1,009,028
57.00	05700	CT SCAN	594,348	1,125,442	1,719,790	-405,572	1,314,218
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	238,138	223,321	461,459	-14,498	446,961
59.00	05900	CARDIAC CATHETERIZATION	1,312,056	8,169,171	9,481,227	-6,806,626	2,674,601
60.00	06000	LABORATORY	0	6,610,564	6,610,564	-2,253	6,608,311
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,843,447	1,053,817	2,897,264	-423,247	2,474,017
66.00	06600	PHYSICAL THERAPY	2,489,578	1,269,766	3,759,344	-1,409,474	2,349,870
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	734,675	734,675
68.00	06800	SPEECH PATHOLOGY	0	0	0	185,711	185,711
69.00	06900	ELECTROCARDIOLOGY	849,198	529,485	1,378,683	-102,179	1,276,504
70.00	07000	ELECTROENCEPHALOGRAPHY	427,543	367,255	794,798	-143,326	651,472
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	906,065	906,065	11,015,337	11,921,402
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,287,602	10,287,602
73.00	07300	DRUGS CHARGED TO PATIENTS	2,675,114	8,542,138	11,217,252	-48,386	11,168,866
74.00	07400	RENAL DIALYSIS	0	419,746	419,746	-4,407	415,339
76.00	03950	ENDOSCOPY	658,304	1,196,490	1,854,794	-797,098	1,057,696
76.06	03330	IMAGING CENTER	798,747	1,109,242	1,907,989	-524,870	1,383,119
76.97	07697	CARDIAC REHABILITATION	241,704	82,634	324,338	-13,792	310,546
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	524,767	161,192	685,959	-18,275	667,684
90.03	04952	PALLIATIVE CARE	0	0	0	0	90.03
90.04	04953	SPINE CENTER	125,166	134,974	260,140	-46,718	213,422
91.00	09100	EMERGENCY	5,340,356	2,835,955	8,176,311	-323,004	7,853,307
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,274,894	141,677,124	202,952,018	1,794	202,953,812
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	126,425	126,425	0	126,425
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	429,538	143,143	572,681	-1,794	570,887
200.00		TOTAL (SUM OF LINES 118 through 199)	61,704,432	141,946,692	203,651,124	0	203,651,124

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0128

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

Worksheet A  
Date/Time Prepared:  
5/29/2019 3:00 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,751,909	6,806,003	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,558,420	9,684,050	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,091,568	3,103,168	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-24,073,159	39,332,446	5.00
7.00	00700	OPERATION OF PLANT	-194,848	5,279,806	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	695,769	8.00
9.00	00900	HOUSEKEEPING	0	2,183,965	9.00
10.00	01000	DIETARY	-45,650	967,825	10.00
11.00	01100	CAFETERIA	-1,357,919	581,935	11.00
13.00	01300	NURSING ADMINISTRATION	2,637,622	2,954,007	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,656,860	1,967,826	16.00
17.00	01700	SOCIAL SERVICE	0	1,574,057	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	593,815	593,815	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	951,622	951,622	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	2,253,668	28,074,646	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,516,790	31.00
43.00	04300	NURSERY	0	947,054	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-7,639	6,033,341	50.00
51.00	05100	RECOVERY ROOM	0	3,510,252	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,102,396	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-471,837	1,929,302	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,009,028	55.00
57.00	05700	CT SCAN	0	1,314,218	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	446,961	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,674,601	59.00
60.00	06000	LABORATORY	-770,138	5,838,173	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,474,017	65.00
66.00	06600	PHYSICAL THERAPY	-31,980	2,317,890	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	734,675	67.00
68.00	06800	SPEECH PATHOLOGY	0	185,711	68.00
69.00	06900	ELECTROCARDIOLOGY	122,689	1,399,193	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	138,621	790,093	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	805,311	12,726,713	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,287,602	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	234,130	11,402,996	73.00
74.00	07400	RENAL DIALYSIS	0	415,339	74.00
76.00	03950	ENDOSCOPY	0	1,057,696	76.00
76.06	03330	IMAGING CENTER	0	1,383,119	76.06
76.97	07697	CARDIAC REHABILITATION	-5,870	304,676	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	-311,672	356,012	90.02
90.03	04952	PALLIATIVE CARE	0	0	90.03
90.04	04953	SPINE CENTER	0	213,422	90.04
91.00	09100	EMERGENCY	-143	7,853,164	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,978,438	188,975,374	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	126,425	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HOME OFFICE	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	570,887	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,978,438	189,672,686	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>A - Chargeable Medical Supplies</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	12,000,645		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
	0		0	12,000,645		
<b>B - Implantable Device Recl ass</b>						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,287,602		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	10,287,602		
<b>C - Drugs Charges to Pat</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,790		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	413,845		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	415,635		
<b>D - Depreciation Expense</b>						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,878,048		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

RECLASSIFICATIONS

Provider CCN: 15-0128

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

Worksheet A-6

Date/Time Prepared:  
5/29/2019 3:00 pm

Increases						
Cost Center	Line #	Salary	Other			
2.00	3.00	4.00	5.00			
19.00	0.00	0	0		19.00	
20.00	0.00	0	0		20.00	
21.00	0.00	0	0		21.00	
22.00	0.00	0	0		22.00	
23.00	0.00	0	0		23.00	
24.00	0.00	0	0		24.00	
25.00	0.00	0	0		25.00	
26.00	0.00	0	0		26.00	
27.00	0.00	0	0		27.00	
28.00	0.00	0	0		28.00	
0			8,878,048			
<b>E - Interest Expense</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,640,464	1.00	
0			0	4,640,464		
<b>F - Other Capital Rental</b>						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,975,409	1.00	
2.00	OPERATION OF PLANT	7.00	0	201,428	2.00	
3.00	EMERGENCY	91.00	0	6,586	3.00	
4.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	5,760	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
0			0	2,189,183		
<b>G - STD BENEFITS</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,643	1.00	
2.00	OPERATION OF PLANT	7.00	0	13,702	2.00	
3.00	HOUSEKEEPING	9.00	0	5,071	3.00	
4.00	DIETARY	10.00	0	3,615	4.00	
5.00	NURSING ADMINISTRATION	13.00	0	319	5.00	
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	287	6.00	
7.00	SOCIAL SERVICE	17.00	0	8,737	7.00	
8.00	ADULTS & PEDIATRICS	30.00	0	157,749	8.00	
9.00	INTENSIVE CARE UNIT	31.00	0	10,491	9.00	
10.00	OPERATING ROOM	50.00	0	9,771	10.00	
11.00	RECOVERY ROOM	51.00	0	29,313	11.00	
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,226	12.00	
13.00	CARDIAC CATHETERIZATION	59.00	0	9,765	13.00	
14.00	RESPIRATORY THERAPY	65.00	0	14,439	14.00	
15.00	PHYSICAL THERAPY	66.00	0	7,221	15.00	
16.00	ELECTROCARDIOLOGY	69.00	0	10,216	16.00	
17.00	ELECTROENCEPHALOGRAPHY	70.00	0	5,726	17.00	
18.00	DRUGS CHARGED TO PATIENTS	73.00	0	19,826	18.00	
19.00	IMAGING CENTER	76.06	0	976	19.00	
20.00	CARDIAC REHABILITATION	76.97	0	1,397	20.00	
21.00	EMERGENCY	91.00	0	23,692	21.00	
0			0	349,182		
<b>H - Labor and Delivery</b>						
1.00	NURSERY	43.00	678,823	0	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,765,125	0	2.00	
3.00	NURSERY	43.00		268,231	3.00	
4.00	DELIVERY ROOM & LABOR ROOM	52.00		697,473	4.00	
			2,443,948	965,704		



		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
<b>I - Cafeteria</b>						
1.00	CAFETERIA	11.00	840,809	0	1.00	
2.00	CAFETERIA	11.00	0	1,099,045	2.00	
	0		840,809	1,099,045		
<b>J - Therapy</b>						
1.00	OCCUPATIONAL THERAPY	67.00	551,540	0	1.00	
2.00	SPEECH PATHOLOGY	68.00	139,418	0	2.00	
3.00	OCCUPATIONAL THERAPY	67.00		183,135	3.00	
4.00	SPEECH PATHOLOGY	68.00		46,293	4.00	
			690,958	229,428		
<b>K - Building Depreciation</b>						
1.00	CAP_REL_COSTS-BLDG & FIXT	1.00	0	4,727,827	1.00	
	0		0	4,727,827		
<b>L - Capital Insurance Costs</b>						
1.00	CAP_REL_COSTS-BLDG & FIXT	1.00	0	189,621	1.00	
	0		0	189,621		
<b>M - Radiology Support Staff</b>						
1.00	RADIOLOGY-THERAPEUTIC	55.00	57,854	0	1.00	
2.00	CT SCAN	57.00	148,763	0	2.00	
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	26,904	0	3.00	
4.00	RADIOLOGY-THERAPEUTIC	55.00		29,530	4.00	
5.00	CT SCAN	57.00		75,931	5.00	
6.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00		13,732	6.00	
			233,521	119,193		
500.00	Grand Total: Increases		4,209,236	46,091,577	500.00	

RECLASSIFICATIONS

Provider CCN: 15-0128

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

Worksheet A-6  
Date/Time Prepared:  
5/29/2019 3:00 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
<b>A - Chargeable Medical Supplies</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,990	0		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	0	613	0		2.00
3.00	DIETARY	10.00	0	413	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	988,368	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	206,511	0		5.00
6.00	OPERATING ROOM	50.00	0	5,544,517	0		6.00
7.00	RECOVERY ROOM	51.00	0	175,450	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	522,319	0		8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0	607,250	0		9.00
10.00	CT SCAN	57.00	0	156,626	0		10.00
11.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	11,322	0		11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	2,505,076	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	340,250	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	45,202	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	9,229	0		15.00
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	24,901	0		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	79,819	0		17.00
18.00	RENAL DIALYSIS	74.00	0	3,831	0		18.00
19.00	ENDOSCOPY	76.00	0	448,881	0		19.00
20.00	IMAGING CENTER	76.06	0	99,385	0		20.00
21.00	CARDIAC REHABILITATION	76.97	0	8,164	0		21.00
22.00	ANTI-COAGULATION CLINIC	90.02	0	1,413	0		22.00
23.00	EMERGENCY	91.00	0	214,386	0		23.00
24.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	1,729	0		24.00
0			0	12,000,645			
<b>B - Implantable Device Recl ass</b>							
1.00	OPERATING ROOM	50.00	0	6,814,599	0		1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00	0	247,589	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	3,225,414	0		3.00
0			0	10,287,602			
<b>C - Drugs Charges to Pat</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	89	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	53,835	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	9,363	0		3.00
4.00	OPERATING ROOM	50.00	0	14,062	0		4.00
5.00	RECOVERY ROOM	51.00	0	5,715	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,506	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	569	0		7.00
8.00	CT SCAN	57.00	0	183,853	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	2,664	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	70,499	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	7,552	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	766	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	372	0		13.00
14.00	ELECTROENCEPHALOGRAPHY	70.00	0	484	0		14.00
15.00	RENAL DIALYSIS	74.00	0	528	0		15.00
16.00	ENDOSCOPY	76.00	0	3,789	0		16.00
17.00	IMAGING CENTER	76.06	0	25,538	0		17.00
18.00	ANTI-COAGULATION CLINIC	90.02	0	29	0		18.00
19.00	EMERGENCY	91.00	0	17,422	0		19.00
TOTALS			0	415,635			
<b>D - Depreciation Expense</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,810,066	9		1.00
2.00	OPERATION OF PLANT	7.00	0	58,409	0		2.00
3.00	HOUSEKEEPING	9.00	0	5,174	0		3.00
4.00	DIETARY	10.00	0	68,422	0		4.00
5.00	SOCIAL SERVICE	17.00	0	1,805	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	469,916	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	178,988	0		7.00
8.00	OPERATING ROOM	50.00	0	1,368,223	0		8.00
9.00	RECOVERY ROOM	51.00	0	33,771	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	338,814	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	105,744	0		11.00
12.00	CT SCAN	57.00	0	289,767	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	41,148	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	1,003,334	0		14.00
15.00	LABORATORY	60.00	0	2,173	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	67,045	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	147,999	0		17.00

RECLASSIFICATIONS

Provider CCN: 15-0128

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

Worksheet A-6  
Date/Time Prepared:  
5/29/2019 3:00 pm

Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
18.00	ELECTROCARDIOLOGY	69.00	0	92,040	0	18.00	
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	35,181	0	19.00	
20.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	30,198	0	20.00	
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	34,471	0	21.00	
22.00	ENDOSCOPY	76.00	0	343,727	0	22.00	
23.00	IMAGING CENTER	76.06	0	211,523	0	23.00	
24.00	CARDIAC REHABILITATION	76.97	0	5,628	0	24.00	
25.00	ANTI-COAGULATION CLINIC	90.02	0	16,793	0	25.00	
26.00	SPINE CENTER	90.04	0	14,082	0	26.00	
27.00	EMERGENCY	91.00	0	97,782	0	27.00	
28.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	5,825	0	28.00	
0			0	8,878,048			
<b>E - Interest Expense</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,640,464	11	1.00	
0			0	4,640,464			
<b>F - Other Capital Rental</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	71	10	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	68,551	0	2.00	
3.00	HOUSEKEEPING	9.00	0	13,627	0	3.00	
4.00	DIETARY	10.00	0	3,993	0	4.00	
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	80	0	5.00	
6.00	SOCIAL SERVICE	17.00	0	471	0	6.00	
7.00	ADULTS & PEDIATRICS	30.00	0	45,291	0	7.00	
8.00	OPERATING ROOM	50.00	0	135,585	0	8.00	
9.00	RECOVERY ROOM	51.00	0	4,514	0	9.00	
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	718	0	10.00	
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	370	0	11.00	
12.00	CT SCAN	57.00	0	20	0	12.00	
13.00	CARDIAC CATHETERIZATION	59.00	0	2,303	0	13.00	
14.00	LABORATORY	60.00	0	80	0	14.00	
15.00	RESPIRATORY THERAPY	65.00	0	8,400	0	15.00	
16.00	PHYSICAL THERAPY	66.00	0	295,121	0	16.00	
17.00	ELECTROCARDIOLOGY	69.00	0	538	0	17.00	
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	82,760	0	18.00	
19.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	956,900	0	19.00	
20.00	DRUGS CHARGED TO PATIENTS	73.00	0	347,941	0	20.00	
21.00	RENAL DIALYSIS	74.00	0	48	0	21.00	
22.00	ENDOSCOPY	76.00	0	701	0	22.00	
23.00	IMAGING CENTER	76.06	0	188,424	0	23.00	
24.00	ANTI-COAGULATION CLINIC	90.02	0	40	0	24.00	
25.00	SPINE CENTER	90.04	0	32,636	0	25.00	
0			0	2,189,183			
<b>G - STD BENEFITS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	11,643	0	0	1.00	
2.00	OPERATION OF PLANT	7.00	13,702	0	0	2.00	
3.00	HOUSEKEEPING	9.00	5,071	0	0	3.00	
4.00	DIETARY	10.00	3,615	0	0	4.00	
5.00	NURSING ADMINISTRATION	13.00	319	0	0	5.00	
6.00	MEDICAL RECORDS & LIBRARY	16.00	287	0	0	6.00	
7.00	SOCIAL SERVICE	17.00	8,737	0	0	7.00	
8.00	ADULTS & PEDIATRICS	30.00	157,749	0	0	8.00	
9.00	INTENSIVE CARE UNIT	31.00	10,491	0	0	9.00	
10.00	OPERATING ROOM	50.00	9,771	0	0	10.00	
11.00	RECOVERY ROOM	51.00	29,313	0	0	11.00	
12.00	RADIOLOGY-DIAGNOSTIC	54.00	5,226	0	0	12.00	
13.00	CARDIAC CATHETERIZATION	59.00	9,765	0	0	13.00	
14.00	RESPIRATORY THERAPY	65.00	14,439	0	0	14.00	
15.00	PHYSICAL THERAPY	66.00	7,221	0	0	15.00	
16.00	ELECTROCARDIOLOGY	69.00	10,216	0	0	16.00	
17.00	ELECTROENCEPHALOGRAPHY	70.00	5,726	0	0	17.00	
18.00	DRUGS CHARGED TO PATIENTS	73.00	19,826	0	0	18.00	
19.00	IMAGING CENTER	76.06	976	0	0	19.00	
20.00	CARDIAC REHABILITATION	76.97	1,397	0	0	20.00	
21.00	EMERGENCY	91.00	23,692	0	0	21.00	
0			349,182	0			
<b>H - Labor and Delivery</b>							
1.00	ADULTS & PEDIATRICS	30.00	2,443,948	0		1.00	
2.00						2.00	
3.00	ADULTS & PEDIATRICS	30.00		965,704		3.00	
4.00						4.00	
			2,443,948	965,704			

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
<b>I - Cafeteria</b>						
1.00	DIETARY	10.00	840,809	0	0	1.00
2.00	DIETARY	10.00	0	1,099,045	0	2.00
			840,809	1,099,045		
<b>J - Therapy</b>						
1.00	PHYSICAL THERAPY	66.00	690,958	0		1.00
2.00						2.00
3.00	PHYSICAL THERAPY	66.00		229,428		3.00
4.00						4.00
			690,958	229,428		
<b>K - Building Depreciation</b>						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,727,827	9	1.00
			0	4,727,827		
<b>L - Capital Insurance Costs</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	189,621	12	1.00
			0	189,621		
<b>M - Radiology Support Staff</b>						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	233,521	0		1.00
2.00						2.00
3.00						3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00		119,193		4.00
5.00						5.00
6.00						6.00
			233,521	119,193		
500.00	Grand Total: Decreases		4,558,418	45,742,395		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/29/2019 3:00 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	2,705,851	0	0	0	0	1.00
2.00	Land Improvements	3,164,637	582,896	0	582,896	0	2.00
3.00	Buildings and Fixtures	313,468,219	7,299,219	0	7,299,219	2,405	3.00
4.00	Building Improvements	1,751,624	845,503	0	845,503	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	108,146,114	5,301,513	0	5,301,513	1,831,439	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	429,236,445	14,029,131	0	14,029,131	1,833,844	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	429,236,445	14,029,131	0	14,029,131	1,833,844	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	2,705,851	0				1.00
2.00	Land Improvements	3,747,533	0				2.00
3.00	Buildings and Fixtures	320,765,033	0				3.00
4.00	Building Improvements	2,597,127	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	111,616,188	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	441,431,732	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	441,431,732	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/29/2019 3:00 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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/29/2019 3:00 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	321,090,331	0	321,090,331	0.748050	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	108,146,114	0	108,146,114	0.251950	0	2.00
3.00	Total (sum of lines 1-2)	429,236,445	0	429,236,445	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,727,827	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	7,708,641	1,975,409	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,436,468	1,975,409	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,888,555	189,621	0	0	6,806,003	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	9,684,050	2.00
3.00	Total (sum of lines 1-2)	1,888,555	189,621	0	0	16,490,053	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0128

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

Worksheet A-8

Date/Time Prepared:  
5/29/2019 3:00 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)	B	-12,834		ADMINISTRATIVE & GENERAL	5.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00		0	7.00
8.00 Television and radio service (chapter 21)			0		0.00		9	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-242,186					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	4,208,529					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-1,265,229		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			0		0.00		0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	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 MISC REVENUE	B		0	CARDIAC REHABILITATION	76.97		0	33.00



ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0128

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

Worksheet A-8

Date/Time Prepared:  
5/29/2019 3:00 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
33.01	Misc Revenue	B	-240	ADMINISTRATIVE & GENERAL	5.00	0 33.01
33.02	Misc Revenue	B	-14,262	OPERATION OF PLANT	7.00	0 33.02
33.03	Misc Revenue	B	-45,650	DIETARY	10.00	0 33.03
33.04	Misc Revenue	B	-455	ADULTS & PEDIATRICS	30.00	0 33.04
33.05	Misc Revenue	B	-7,639	OPERATING ROOM	50.00	0 33.05
33.06	Misc Revenue	B	-549,619	RADIOLOGY-DIAGNOSTIC	54.00	0 33.06
33.07	Misc Revenue	B	-770,138	LABORATORY	60.00	0 33.07
33.08	Misc Revenue	B	-31,980	PHYSICAL THERAPY	66.00	0 33.08
33.09	Misc Revenue	B	-8,224	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0 33.09
33.10	Misc Revenue	B	-19,500	DRUGS CHARGED TO PATIENTS	73.00	0 33.10
33.11	Misc Revenue	B	-5,870	CARDIAC REHABILITATION	76.97	0 33.11
33.12	Misc Revenue	B	-143	EMERGENCY	91.00	0 33.12
33.13	Space Rental Income	B	-541,098	OPERATION OF PLANT	7.00	0 33.13
34.00	HAF Tax Offset	A	-11,545,682	ADMINISTRATIVE & GENERAL	5.00	0 34.00
34.01	LOC Non-Allow Interest Expense	A	-27,819	CAP REL COSTS-BLDG & FIXT	1.00	11 34.01
34.02	Non-Allowable Interest Expense 00	A	-721,067	CAP REL COSTS-BLDG & FIXT	1.00	11 34.02
34.03	2012B Non-Allow Interest Expense	A	-91,191	CAP REL COSTS-BLDG & FIXT	1.00	11 34.03
34.04	50M BMO Non-Allow Interest Expense	A	-53,338	CAP REL COSTS-BLDG & FIXT	1.00	11 34.04
34.05	12B Non-Allow Interest Expense	A	-379,900	CAP REL COSTS-BLDG & FIXT	1.00	11 34.05
34.06	50 BMO Loan Non-Allow Interest Expense	A	32,228	ADMINISTRATIVE & GENERAL	5.00	0 34.06
34.07	NON-ALLOWABLE INTEREST EXPENSE 18A	A	-1,478,594	CAP REL COSTS-BLDG & FIXT	1.00	11 34.07
36.00	Meals of Wheels Cost	A	-92,690	CAFETERIA	11.00	0 36.00
36.01	Non Allow Sponsorship	A	-2,175	ADMINISTRATIVE & GENERAL	5.00	0 36.01
36.02	Nurse Practitioner Offset	A	-311,672	ANTI-COAGULATION CLINIC	90.02	0 36.02
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,978,438			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: 15-0128  
 Period: From 01/01/2018 To 12/31/2018  
 Worksheet A-8-1  
 Date/Time Prepared: 5/29/2019 3:00 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	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	5.00	ADMINISTRATIVE & GENERAL	1550 CTY LN RD	94,089	67,057 1.00
2.00	30.00	ADULTS & PEDIATRICS	1550 CTY LN RD	55,310	39,420 2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	3,558,420	0 3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	3,091,568	0 3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	32,057,039	44,558,080 3.02
3.03	7.00	OPERATION OF PLANT	HOME OFFICE	360,512	0 3.03
3.04	13.00	NURSING ADMINISTRATION	HOME OFFICE	2,637,622	0 3.04
3.05	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	1,656,860	0 3.05
3.06	30.00	ADULTS & PEDIATRICS	HOME OFFICE	409,970	0 3.06
3.07	30.00	ADULTS & PEDIATRICS	HOME OFFICE	1,828,263	0 3.07
3.08	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	77,782	0 3.08
3.09	69.00	ELECTROCARDIOLOGY	HOME OFFICE	122,689	0 3.09
3.10	70.00	ELECTROENCEPHALOGRAPHY	HOME OFFICE	138,621	0 3.10
3.11	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	813,535	0 3.11
3.12	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	253,630	0 3.12
4.00	21.00	I&R SERVICES-SALARY & FRINGE	INTERNS & RESIDENTS	593,815	0 4.00
4.01	22.00	I&R SERVICES-OTHER PRGM. COS	INTERNS & RESIDENTS	951,622	0 4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR AND CAL	171,739	0 4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			48,873,086	44,664,557 5.00

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

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

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	C	CHNW	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER			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: 15-0128

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

Worksheet A-8-1

Date/Time Prepared:  
5/29/2019 3:00 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	27,032	0		1.00
2.00	15,890	0		2.00
3.00	3,558,420	9		3.00
3.01	3,091,568	0		3.01
3.02	-12,501,041	0		3.02
3.03	360,512	0		3.03
3.04	2,637,622	0		3.04
3.05	1,656,860	0		3.05
3.06	409,970	0		3.06
3.07	1,828,263	0		3.07
3.08	77,782	0		3.08
3.09	122,689	0		3.09
3.10	138,621	0		3.10
3.11	813,535	0		3.11
3.12	253,630	0		3.12
4.00	593,815	0		4.00
4.01	951,622	0		4.01
4.02	171,739	0		4.02
5.00	4,208,529			5.00

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

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

**B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:**

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0128

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

Worksheet A-8-2

Date/Time Prepared:  
5/29/2019 3:00 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	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	453,686	29,031	424,655	211,500	2,080	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			453,686	29,031	424,655		2,080	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	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	211,500	10,575	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			211,500	10,575	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	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	211,500	213,155	242,186		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	211,500	213,155	242,186		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2019 3:00 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	6,806,003	6,806,003			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	9,684,050		9,684,050		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,103,168	0	0	3,103,168	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	39,332,446	956,982	3,696,245	208,224	44,193,897
7.00 00700	OPERATION OF PLANT	5,279,806	904,047	0	76,873	6,260,726
8.00 00800	LAUNDRY & LINEN SERVICE	695,769	18,912	0	0	714,681
9.00 00900	HOUSEKEEPING	2,183,965	41,520	18,431	63,788	2,307,704
10.00 01000	DIETARY	967,825	72,552	24,232	19,163	1,083,772
11.00 01100	CAFETERIA	581,935	153,081	46,104	42,530	823,650
13.00 01300	NURSING ADMINISTRATION	2,954,007	0	0	13,453	2,967,460
16.00 01600	MEDICAL RECORDS & LIBRARY	1,967,826	0	78	12,822	1,980,726
17.00 01700	SOCIAL SERVICE	1,574,057	18,998	2,231	62,668	1,657,954
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	593,815	0	0	0	593,815
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	951,622	0	0	0	951,622
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	28,074,646	1,776,066	279,851	976,027	31,106,590
31.00 03100	INTENSIVE CARE UNIT	3,516,790	521,326	175,469	134,910	4,348,495
43.00 04300	NURSERY	947,054	66,105	17,358	34,336	1,064,853
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	6,033,341	595,391	920,727	163,480	7,712,939
51.00 05100	RECOVERY ROOM	3,510,252	147,012	37,213	129,443	3,823,920
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,102,396	174,039	45,135	118,304	3,439,874
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,929,302	211,690	302,278	73,709	2,516,979
55.00 05500	RADIOLOGY-THERAPEUTIC	1,009,028	0	103,321	31,076	1,143,425
57.00 05700	CT SCAN	1,314,218	26,029	266,553	37,588	1,644,388
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	446,961	30,310	10,461	13,406	501,138
59.00 05900	CARDIAC CATHETERIZATION	2,674,601	190,836	760,281	65,872	3,691,590
60.00 06000	LABORATORY	5,838,173	89,057	78	0	5,927,308
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	2,474,017	44,442	72,020	92,515	2,682,994
66.00 06600	PHYSICAL THERAPY	2,317,890	14,682	539,229	90,613	2,962,414
67.00 06700	OCCUPATIONAL THERAPY	734,675	4,556	32,143	27,898	799,272
68.00 06800	SPEECH PATHOLOGY	185,711	1,203	8,125	7,052	202,091
69.00 06900	ELECTROCARDIOLOGY	1,399,193	107,332	63,063	42,437	1,612,025
70.00 07000	ELECTROENCEPHALOGRAPHY	790,093	43,291	115,621	21,336	970,341
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,726,713	0	967,666	0	13,694,379
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	10,287,602	0	0	0	10,287,602
73.00 07300	DRUGS CHARGED TO PATIENTS	11,402,996	25,256	365,010	134,310	11,927,572
74.00 07400	RENAL DIALYSIS	415,339	20,975	47	0	436,361
76.00 03950	ENDOSCOPY	1,057,696	0	296,116	33,298	1,387,110
76.06 03330	IMAGING CENTER	1,383,119	0	392,084	40,353	1,815,556
76.97 07697	CARDIAC REHABILITATION	304,676	0	5,517	12,155	322,348
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02 04951	ANTI-COAGULATION CLINIC	356,012	0	3,559	26,544	386,115
90.03 04952	PALLIATIVE CARE	0	0	0	0	0
90.04 04953	SPINE CENTER	213,422	0	45,716	6,331	265,469
91.00 09100	EMERGENCY	7,853,164	518,266	72,024	268,927	8,712,381
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	188,975,374	6,773,956	9,683,986	3,081,441	188,921,536
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	126,425	0	0	0	126,425
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	HOME OFFICE	0	0	0	0	0
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	0
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	570,887	32,047	64	21,727	624,725
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	189,672,686	6,806,003	9,684,050	3,103,168	189,672,686

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0128		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part I Date/Time Prepared: 5/29/2019 3:00 pm	
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	44,193,897					5.00
7.00	00700	OPERATION OF PLANT	1,901,896	8,162,622				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	217,107	31,217	963,005			8.00
9.00	00900	HOUSEKEEPING	701,039	68,536	0	3,077,279		9.00
10.00	01000	DIETARY	329,230	119,761	0	45,708	1,578,471	10.00
11.00	01100	CAFETERIA	250,210	252,690	0	96,442	0	11.00
13.00	01300	NURSING ADMINISTRATION	901,461	0	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	601,709	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	503,657	31,359	0	11,969	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	180,390	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	289,086	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	9,449,680	2,931,733	432,611	1,118,927	1,447,344	30.00
31.00	03100	INTENSIVE CARE UNIT	1,320,995	860,548	49,576	328,437	131,127	31.00
43.00	04300	NURSERY	323,483	109,119	12,125	41,646	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	2,343,052	982,807	0	375,099	0	50.00
51.00	05100	RECOVERY ROOM	1,161,638	242,672	147,895	92,618	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,044,972	287,285	31,524	109,645	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	764,613	349,435	14,696	133,366	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	347,352	0	0	0	0	55.00
57.00	05700	CT SCAN	499,535	42,966	76,103	16,399	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	152,237	50,033	0	19,096	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,121,439	315,011	10,655	120,227	0	59.00
60.00	06000	LABORATORY	1,800,609	147,005	0	56,106	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	815,045	73,361	0	27,999	0	65.00
66.00	06600	PHYSICAL THERAPY	899,928	24,236	0	9,250	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	242,804	7,521	0	2,870	0	67.00
68.00	06800	SPEECH PATHOLOGY	61,392	1,987	0	758	0	68.00
69.00	06900	ELECTROCARDIOLOGY	489,704	177,173	0	67,620	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	294,772	71,459	0	27,273	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,160,106	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,125,188	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,623,382	41,689	0	15,911	0	73.00
74.00	07400	RENAL DIALYSIS	132,559	34,623	0	13,214	0	74.00
76.00	03950	ENDOSCOPY	421,379	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	551,533	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	97,924	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	117,295	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	80,645	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,646,665	855,497	187,820	326,509	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,965,711	8,109,723	963,005	3,057,089	1,578,471	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,406	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	189,780	52,899	0	20,190	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	44,193,897	8,162,622	963,005	3,077,279	1,578,471	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2019 3:00 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS	SERVICES-SALARY & FRINGES	
	11.00	13.00	16.00	17.00	21.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100							1.00
2.00 00200							2.00
4.00 00400							4.00
5.00 00500							5.00
7.00 00700							7.00
8.00 00800							8.00
9.00 00900							9.00
10.00 01000							10.00
11.00 01100	1,422,992						11.00
13.00 01300	16,498	3,885,419					13.00
16.00 01600	6,187	0	2,588,622				16.00
17.00 01700	32,997	0	0	2,237,936			17.00
21.00 02100	0	0	0	0	774,205		21.00
22.00 02200	0	0	0	0	0		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	569,198	2,742,649	324,560	1,897,911	588,915		30.00
31.00 03100	59,807	288,177	28,623	161,725	45,787		31.00
43.00 04300	18,561	89,434	12,095	178,300	0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	96,928	0	297,705	0	24,781		50.00
51.00 05100	63,932	0	97,691	0	0		51.00
52.00 05200	47,433	0	30,172	0	0		52.00
54.00 05400	45,371	0	93,546	0	8,080		54.00
55.00 05500	16,498	0	58,499	0	0		55.00
57.00 05700	22,685	0	168,600	0	0		57.00
58.00 05800	8,249	0	29,826	0	0		58.00
59.00 05900	32,997	0	186,548	0	0		59.00
60.00 06000	0	0	224,727	0	0		60.00
64.00 06400	0	0	0	0	0		64.00
65.00 06500	49,495	0	38,497	0	0		65.00
66.00 06600	22,685	0	28,521	0	0		66.00
67.00 06700	14,436	0	9,262	0	0		67.00
68.00 06800	4,125	0	2,341	0	0		68.00
69.00 06900	35,059	0	75,334	0	0		69.00
70.00 07000	12,374	0	13,456	0	8,345		70.00
71.00 07100	0	0	134,669	0	0		71.00
72.00 07200	0	0	99,243	0	0		72.00
73.00 07300	61,869	0	179,781	0	0		73.00
74.00 07400	0	0	3,773	0	0		74.00
76.00 03950	14,436	0	31,333	0	0		76.00
76.06 03330	2,062	0	37,390	0	0		76.06
76.97 07697	10,312	0	3,986	0	0		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	0	0	0	0	0		90.00
90.01 04950	0	0	0	0	0		90.01
90.02 04951	0	0	3,890	0	0		90.02
90.03 04952	0	0	0	0	0		90.03
90.04 04953	0	0	1,033	0	0		90.04
91.00 09100	158,798	765,159	373,521	0	65,977		91.00
92.00 09200	0	0	0	0	0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	1,422,992	3,885,419	2,588,622	2,237,936	741,885		118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	0	0	0	0	0		190.00
191.00 19100	0	0	0	0	0		191.00
192.00 19200	0	0	0	0	0		192.00
193.00 19300	0	0	0	0	0		193.00
194.00 07950	0	0	0	0	0		194.00
194.06 07956	0	0	0	0	0		194.06
194.08 07958	0	0	0	0	32,320		194.08
200.00	0	0	0	0	0		200.00
201.00	0	0	0	0	0		201.00
202.00	1,422,992	3,885,419	2,588,622	2,237,936	774,205		202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Prepared: 5/29/2019 3:00 pm
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Cost Center Description	INTERNS & RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	SERVICES-OTHER PRGM. COSTS					
	22.00	24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00 00500	ADMINISTRATIVE & GENERAL				5.00	
7.00 00700	OPERATION OF PLANT				7.00	
8.00 00800	LAUNDRY & LINEN SERVICE				8.00	
9.00 00900	HOUSEKEEPING				9.00	
10.00 01000	DIETARY				10.00	
11.00 01100	CAFETERIA				11.00	
13.00 01300	NURSING ADMINISTRATION				13.00	
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00 01700	SOCIAL SERVICE				17.00	
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00	
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,240,708			22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	943,770	53,553,888	-1,532,685	52,021,203	30.00
31.00 03100	INTENSIVE CARE UNIT	73,376	7,696,673	-119,163	7,577,510	31.00
43.00 04300	NURSERY	0	1,849,616	0	1,849,616	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	39,712	11,873,023	-64,493	11,808,530	50.00
51.00 05100	RECOVERY ROOM	0	5,630,366	0	5,630,366	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	4,990,905	0	4,990,905	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	12,949	3,939,035	-21,029	3,918,006	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	1,565,774	0	1,565,774	55.00
57.00 05700	CT SCAN	0	2,470,676	0	2,470,676	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	760,579	0	760,579	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	5,478,467	0	5,478,467	59.00
60.00 06000	LABORATORY	0	8,155,755	0	8,155,755	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	3,687,391	0	3,687,391	65.00
66.00 06600	PHYSICAL THERAPY	0	3,947,034	0	3,947,034	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	1,076,165	0	1,076,165	67.00
68.00 06800	SPEECH PATHOLOGY	0	272,694	0	272,694	68.00
69.00 06900	ELECTROCARDIOLOGY	0	2,456,915	0	2,456,915	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	13,374	1,411,394	-21,719	1,389,675	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,989,154	0	17,989,154	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,512,033	0	13,512,033	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	15,850,204	0	15,850,204	73.00
74.00 07400	RENAL DIALYSIS	0	620,530	0	620,530	74.00
76.00 03950	ENDOSCOPY	0	1,854,258	0	1,854,258	76.00
76.06 03330	IMAGING CENTER	0	2,406,541	0	2,406,541	76.06
76.97 07697	CARDIAC REHABILITATION	0	434,570	0	434,570	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	90.01
90.02 04951	ANTI-COAGULATION CLINIC	0	507,300	0	507,300	90.02
90.03 04952	PALLIATIVE CARE	0	0	0	0	90.03
90.04 04953	SPINE CENTER	0	347,147	0	347,147	90.04
91.00 09100	EMERGENCY	105,732	14,198,059	-171,709	14,026,350	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,188,913	188,536,146	-1,930,798	186,605,348	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	164,831	0	164,831	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	194.06
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	51,795	971,709	-84,115	887,594	194.08
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,240,708	189,672,686	-2,014,913	187,657,773	202.00



ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/29/2019 3:00 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
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	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	956,982	3,696,245	4,653,227	5.00
7.00 00700	OPERATION OF PLANT	0	904,047	0	904,047	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	18,912	0	18,912	8.00
9.00 00900	HOUSEKEEPING	0	41,520	18,431	59,951	9.00
10.00 01000	DIETARY	0	72,552	24,232	96,784	10.00
11.00 01100	CAFETERIA	0	153,081	46,104	199,185	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	78	78	16.00
17.00 01700	SOCIAL SERVICE	0	18,998	2,231	21,229	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	1,776,066	279,851	2,055,917	30.00
31.00 03100	INTENSIVE CARE UNIT	0	521,326	175,469	696,795	31.00
43.00 04300	NURSERY	0	66,105	17,358	83,463	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	595,391	920,727	1,516,118	50.00
51.00 05100	RECOVERY ROOM	0	147,012	37,213	184,225	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	174,039	45,135	219,174	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	211,690	302,278	513,968	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	103,321	103,321	55.00
57.00 05700	CT SCAN	0	26,029	266,553	292,582	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	30,310	10,461	40,771	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	190,836	760,281	951,117	59.00
60.00 06000	LABORATORY	0	89,057	78	89,135	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	44,442	72,020	116,462	65.00
66.00 06600	PHYSICAL THERAPY	0	14,682	539,229	553,911	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	4,556	32,143	36,699	67.00
68.00 06800	SPEECH PATHOLOGY	0	1,203	8,125	9,328	68.00
69.00 06900	ELECTROCARDIOLOGY	0	107,332	63,063	170,395	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	43,291	115,621	158,912	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	967,666	967,666	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	25,256	365,010	390,266	73.00
74.00 07400	RENAL DIALYSIS	0	20,975	47	21,022	74.00
76.00 03950	ENDOSCOPY	0	0	296,116	296,116	76.00
76.06 03330	IMAGING CENTER	0	0	392,084	392,084	76.06
76.97 07697	CARDIAC REHABILITATION	0	0	5,517	5,517	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	90.01
90.02 04951	ANTI-COAGULATION CLINIC	0	0	3,559	3,559	90.02
90.03 04952	PALLIATIVE CARE	0	0	0	0	90.03
90.04 04953	SPINE CENTER	0	0	45,716	45,716	90.04
91.00 09100	EMERGENCY	0	518,266	72,024	590,290	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	6,773,956	9,683,986	16,457,942	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	194.06
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	0	32,047	64	32,111	194.08
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	6,806,003	9,684,050	16,490,053	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0128		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part II Date/Time Prepared: 5/29/2019 3:00 pm		
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	4,653,227				5.00	
7.00	00700	OPERATION OF PLANT	200,256	1,104,303			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	22,860	4,223	45,995		8.00	
9.00	00900	HOUSEKEEPING	73,814	9,272	0	143,037	9.00	
10.00	01000	DIETARY	34,666	16,202	0	2,125	10.00	
11.00	01100	CAFETERIA	26,345	34,186	0	4,483	11.00	
13.00	01300	NURSING ADMINISTRATION	94,917	0	0	0	13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	63,356	0	0	0	16.00	
17.00	01700	SOCIAL SERVICE	53,031	4,243	0	556	17.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	18,994	0	0	0	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	30,439	0	0	0	22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	994,920	396,627	20,661	52,011	30.00	
31.00	03100	INTENSIVE CARE UNIT	139,091	116,422	2,368	15,266	31.00	
43.00	04300	NURSERY	34,060	14,762	579	1,936	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	246,706	132,962	0	17,435	50.00	
51.00	05100	RECOVERY ROOM	122,312	32,831	7,064	4,305	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	110,028	38,866	1,506	5,096	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	80,508	47,274	702	6,199	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	36,574	0	0	0	55.00	
57.00	05700	CT SCAN	52,597	5,813	3,635	762	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	16,029	6,769	0	888	58.00	
59.00	05900	CARDIAC CATHETERIZATION	118,079	42,617	509	5,588	59.00	
60.00	06000	LABORATORY	189,591	19,888	0	2,608	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	85,818	9,925	0	1,301	65.00	
66.00	06600	PHYSICAL THERAPY	94,756	3,279	0	430	66.00	
67.00	06700	OCCUPATIONAL THERAPY	25,566	1,017	0	133	67.00	
68.00	06800	SPEECH PATHOLOGY	6,464	269	0	35	68.00	
69.00	06900	ELECTROCARDIOLOGY	51,562	23,969	0	3,143	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	31,037	9,668	0	1,268	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	438,028	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	329,059	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	381,515	5,640	0	740	73.00	
74.00	07400	RENAL DIALYSIS	13,957	4,684	0	614	74.00	
76.00	03950	ENDOSCOPY	44,368	0	0	0	76.00	
76.06	03330	IMAGING CENTER	58,072	0	0	0	76.06	
76.97	07697	CARDIAC REHABILITATION	10,311	0	0	0	76.97	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	90.00	
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	90.01	
90.02	04951	ANTI-COAGULATION CLINIC	12,350	0	0	0	90.02	
90.03	04952	PALLIATIVE CARE	0	0	0	0	90.03	
90.04	04953	SPINE CENTER	8,491	0	0	0	90.04	
91.00	09100	EMERGENCY	278,674	115,738	8,971	15,177	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,629,201	1,097,146	45,995	142,099	149,777	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00	
191.00	19100	RESEARCH	0	0	0	0	191.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,044	0	0	0	192.00	
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00	
194.00	07950	HOME OFFICE	0	0	0	0	194.00	
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	194.06	
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	19,982	7,157	0	938	194.08	
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)	4,653,227	1,104,303	45,995	143,037	149,777	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/29/2019 3:00 pm		
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES
		11.00	13.00	16.00	17.00	21.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100	264,199				11.00
13.00	01300	3,063	97,980			13.00
16.00	01600	1,149	0	64,583		16.00
17.00	01700	6,126	0	0	85,185	17.00
21.00	02100	0	0	0	0	21.00
22.00	02200	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	105,680	69,163	8,051	72,242	30.00
31.00	03100	11,104	7,267	710	6,156	31.00
43.00	04300	3,446	2,255	300	6,787	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	17,996	0	7,385	0	50.00
51.00	05100	11,870	0	2,423	0	51.00
52.00	05200	8,807	0	748	0	52.00
54.00	05400	8,424	0	2,320	0	54.00
55.00	05500	3,063	0	1,451	0	55.00
57.00	05700	4,212	0	4,182	0	57.00
58.00	05800	1,532	0	740	0	58.00
59.00	05900	6,126	0	4,627	0	59.00
60.00	06000	0	0	5,574	0	60.00
64.00	06400	0	0	0	0	64.00
65.00	06500	9,190	0	955	0	65.00
66.00	06600	4,212	0	707	0	66.00
67.00	06700	2,680	0	230	0	67.00
68.00	06800	766	0	58	0	68.00
69.00	06900	6,509	0	1,869	0	69.00
70.00	07000	2,297	0	334	0	70.00
71.00	07100	0	0	3,340	0	71.00
72.00	07200	0	0	2,462	0	72.00
73.00	07300	11,487	0	4,459	0	73.00
74.00	07400	0	0	94	0	74.00
76.00	03950	2,680	0	777	0	76.00
76.06	03330	383	0	927	0	76.06
76.97	07697	1,914	0	99	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	0	0	0	0	90.00
90.01	04950	0	0	0	0	90.01
90.02	04951	0	0	96	0	90.02
90.03	04952	0	0	0	0	90.03
90.04	04953	0	0	26	0	90.04
91.00	09100	29,483	19,295	9,639	0	91.00
92.00	09200					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		264,199	97,980	64,583	85,185	0
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
191.00	19100	0	0	0	0	191.00
192.00	19200	0	0	0	0	192.00
193.00	19300	0	0	0	0	193.00
194.00	07950	0	0	0	0	194.00
194.06	07956	0	0	0	0	194.06
194.08	07958	0	0	0	0	194.08
200.00						18,994
201.00		0	0	0	0	0
202.00		264,199	97,980	64,583	85,185	18,994

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/29/2019 3:00 pm
Cost Center Description	INTERNS & RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	SERVICES-OTHER PRGM. COSTS				
	22.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	30,439		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	3,912,607	0	3,912,607
31.00	03100	INTENSIVE CARE UNIT	1,007,621	0	1,007,621
43.00	04300	NURSERY	147,588	0	147,588
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	1,938,602	0	1,938,602
51.00	05100	RECOVERY ROOM	365,030	0	365,030
52.00	05200	DELIVERY ROOM & LABOR ROOM	384,225	0	384,225
54.00	05400	RADIOLOGY-DIAGNOSTIC	659,395	0	659,395
55.00	05500	RADIOLOGY-THERAPEUTIC	144,409	0	144,409
57.00	05700	CT SCAN	363,783	0	363,783
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	66,729	0	66,729
59.00	05900	CARDIAC CATHETERIZATION	1,128,663	0	1,128,663
60.00	06000	LABORATORY	306,796	0	306,796
64.00	06400	INTRAVENOUS THERAPY	0	0	0
65.00	06500	RESPIRATORY THERAPY	223,651	0	223,651
66.00	06600	PHYSICAL THERAPY	657,295	0	657,295
67.00	06700	OCCUPATIONAL THERAPY	66,325	0	66,325
68.00	06800	SPEECH PATHOLOGY	16,920	0	16,920
69.00	06900	ELECTROCARDIOLOGY	257,447	0	257,447
70.00	07000	ELECTROENCEPHALOGRAPHY	203,516	0	203,516
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,409,034	0	1,409,034
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	331,521	0	331,521
73.00	07300	DRUGS CHARGED TO PATIENTS	794,107	0	794,107
74.00	07400	RENAL DIALYSIS	40,371	0	40,371
76.00	03950	ENDOSCOPY	343,941	0	343,941
76.06	03330	IMAGING CENTER	451,466	0	451,466
76.97	07697	CARDIAC REHABILITATION	17,841	0	17,841
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	0
90.01	04950	DIABETIC CARE CENTER	0	0	0
90.02	04951	ANTI-COAGULATION CLINIC	16,005	0	16,005
90.03	04952	PALLIATIVE CARE	0	0	0
90.04	04953	SPINE CENTER	54,233	0	54,233
91.00	09100	EMERGENCY	1,067,267	0	1,067,267
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	16,376,388	16,376,388
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0
191.00	19100	RESEARCH	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,044	0	4,044
193.00	19300	NONPAID WORKERS	0	0	0
194.00	07950	HOME OFFICE	0	0	0
194.06	07956	LEASED OFFICE SPACE	0	0	0
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	60,188	0	60,188
200.00		Cross Foot Adjustments	30,439	49,433	49,433
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	30,439	16,490,053	16,490,053

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1  
Date/Time Prepared:  
5/29/2019 3:00 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	395,872				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		9,878,270			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	61,349,621		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	55,663	3,770,378	4,116,557	-44,193,897	145,478,789
7.00 00700	OPERATION OF PLANT	52,584	0	1,519,771	0	6,260,726
8.00 00800	LAUNDRY & LINEN SERVICE	1,100	0	0	0	714,681
9.00 00900	HOUSEKEEPING	2,415	18,801	1,261,085	0	2,307,704
10.00 01000	DIETARY	4,220	24,718	378,848	0	1,083,772
11.00 01100	CAFETERIA	8,904	47,029	840,809	0	823,650
13.00 01300	NURSING ADMINISTRATION	0	0	265,968	0	2,967,460
16.00 01600	MEDICAL RECORDS & LIBRARY	0	80	253,493	0	1,980,726
17.00 01700	SOCIAL SERVICE	1,105	2,276	1,238,948	0	1,657,954
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	593,815
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	951,622
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	103,305	285,463	19,296,275	0	31,106,590
31.00 03100	INTENSIVE CARE UNIT	30,323	178,988	2,667,157	0	4,348,495
43.00 04300	NURSERY	3,845	17,706	678,823	0	1,064,853
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	34,631	939,192	3,231,973	0	7,712,939
51.00 05100	RECOVERY ROOM	8,551	37,959	2,559,067	0	3,823,920
52.00 05200	DELIVERY ROOM & LABOR ROOM	10,123	46,040	2,338,851	0	3,439,874
54.00 05400	RADIOLOGY-DIAGNOSTIC	12,313	308,340	1,457,223	0	2,516,979
55.00 05500	RADIOLOGY-THERAPEUTIC	0	105,393	614,360	0	1,143,425
57.00 05700	CT SCAN	1,514	271,899	743,111	0	1,644,388
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,763	10,671	265,042	0	501,138
59.00 05900	CARDIAC CATHETERIZATION	11,100	775,529	1,302,291	0	3,691,590
60.00 06000	LABORATORY	5,180	80	0	0	5,927,308
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	2,585	73,464	1,829,008	0	2,682,994
66.00 06600	PHYSICAL THERAPY	854	550,043	1,791,399	0	2,962,414
67.00 06700	OCCUPATIONAL THERAPY	265	32,788	551,540	0	799,272
68.00 06800	SPEECH PATHOLOGY	70	8,288	139,418	0	202,091
69.00 06900	ELECTROCARDIOLOGY	6,243	64,328	838,982	0	1,612,025
70.00 07000	ELECTROENCEPHALOGRAPHY	2,518	117,940	421,817	0	970,341
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	987,073	0	0	13,694,379
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10,287,602
73.00 07300	DRUGS CHARGED TO PATIENTS	1,469	372,330	2,655,288	0	11,927,572
74.00 07400	RENAL DIALYSIS	1,220	48	0	0	436,361
76.00 03950	ENDOSCOPY	0	302,055	658,304	0	1,387,110
76.06 03330	IMAGING CENTER	0	399,947	797,771	0	1,815,556
76.97 07697	CARDIAC REHABILITATION	0	5,628	240,307	0	322,348
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02 04951	ANTI-COAGULATION CLINIC	0	3,630	524,767	0	386,115
90.03 04952	PALLIATIVE CARE	0	0	0	0	0
90.04 04953	SPINE CENTER	0	46,633	125,166	0	265,469
91.00 09100	EMERGENCY	30,145	73,468	5,316,664	0	8,712,381
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	394,008	9,878,205	60,920,083	-44,193,897	144,727,639
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	126,425
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	HOME OFFICE	0	0	0	0	0
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	0
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	1,864	65	429,538	0	624,725
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	6,806,003	9,684,050	3,103,168		44,193,897
203.00	Unit cost multiplier (Wkst. B, Part I)	17.192433	0.980339	0.050582		0.303782
204.00	Cost to be allocated (per Wkst. B, Part II)			0		4,653,227

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1  
Date/Time Prepared:  
5/29/2019 3:00 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
205.00	Unit cost multiplier (Wkst. B, Part II)					205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		0.000000		0.031986	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1

Date/Time Prepared:  
5/29/2019 3:00 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	287,625				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,100	39,316			8.00
9.00	00900	HOUSEKEEPING	2,415	0	284,110		9.00
10.00	01000	DIETARY	4,220	0	4,220	34,765	10.00
11.00	01100	CAFETERIA	8,904	0	8,904	0	690
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	8
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	3
17.00	01700	SOCIAL SERVICE	1,105	0	1,105	0	16
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	103,305	17,662	103,305	31,877	276
31.00	03100	INTENSIVE CARE UNIT	30,323	2,024	30,323	2,888	29
43.00	04300	NURSERY	3,845	495	3,845	0	9
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	34,631	0	34,631	0	47
51.00	05100	RECOVERY ROOM	8,551	6,038	8,551	0	31
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,123	1,287	10,123	0	23
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,313	600	12,313	0	22
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	8
57.00	05700	CT SCAN	1,514	3,107	1,514	0	11
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,763	0	1,763	0	4
59.00	05900	CARDIAC CATHETERIZATION	11,100	435	11,100	0	16
60.00	06000	LABORATORY	5,180	0	5,180	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,585	0	2,585	0	24
66.00	06600	PHYSICAL THERAPY	854	0	854	0	11
67.00	06700	OCCUPATIONAL THERAPY	265	0	265	0	7
68.00	06800	SPEECH PATHOLOGY	70	0	70	0	2
69.00	06900	ELECTROCARDIOLOGY	6,243	0	6,243	0	17
70.00	07000	ELECTROENCEPHALOGRAPHY	2,518	0	2,518	0	6
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,469	0	1,469	0	30
74.00	07400	RENAL DIALYSIS	1,220	0	1,220	0	0
76.00	03950	ENDOSCOPY	0	0	0	0	7
76.06	03330	IMAGING CENTER	0	0	0	0	1
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	5
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0
90.03	04952	PALLIATIVE CARE	0	0	0	0	0
90.04	04953	SPINE CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	30,145	7,668	30,145	0	77
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	285,761	39,316	282,246	34,765	690
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0	0
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	1,864	0	1,864	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	8,162,622	963,005	3,077,279	1,578,471	1,422,992
203.00		Unit cost multiplier (Wkst. B, Part I)	28.379390	24.493972	10.831294	45.404027	2,062.307246
204.00		Cost to be allocated (per Wkst. B, Part II)	1,104,303	45,995	143,037	149,777	264,199
205.00		Unit cost multiplier (Wkst. B, Part II)	3.839385	1.169880	0.503456	4.308270	382.897101
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1

Date/Time Prepared:  
5/29/2019 3:00 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1  
Date/Time Prepared:  
5/29/2019 3:00 pm

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS			
				SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
				13.00	16.00		17.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00	
5.00 00500 ADMINISTRATIVE & GENERAL						5.00	
7.00 00700 OPERATION OF PLANT						7.00	
8.00 00800 LAUNDRY & LINEN SERVICE						8.00	
9.00 00900 HOUSEKEEPING						9.00	
10.00 01000 DIETARY						10.00	
11.00 01100 CAFETERIA						11.00	
13.00 01300 NURSING ADMINISTRATION	391					13.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	917,188,279				16.00	
17.00 01700 SOCIAL SERVICE	0	0	39,964			17.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	78,762		21.00	
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	78,762	22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	276	115,010,803	33,892	59,912	59,912	30.00	
31.00 03100 INTENSIVE CARE UNIT	29	10,142,635	2,888	4,658	4,658	31.00	
43.00 04300 NURSERY	9	4,286,079	3,184	0	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	105,494,392	0	2,521	2,521	50.00	
51.00 05100 RECOVERY ROOM	0	34,617,569	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	10,691,539	0	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	33,148,773	0	822	822	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	0	20,729,483	0	0	0	55.00	
57.00 05700 CT SCAN	0	59,744,987	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	10,568,944	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	66,104,731	0	0	0	59.00	
60.00 06000 LABORATORY	0	79,633,893	0	0	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	0	13,641,721	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0	10,106,814	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	3,282,145	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	829,539	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	26,695,424	0	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	4,768,085	0	849	849	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	47,721,155	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	35,167,672	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	63,706,873	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	1,337,073	0	0	0	74.00	
76.00 03950 ENDOSCOPY	0	11,103,102	0	0	0	76.00	
76.06 03330 IMAGING CENTER	0	13,249,405	0	0	0	76.06	
76.97 07697 CARDIAC REHABILITATION	0	1,412,301	0	0	0	76.97	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
90.01 04950 DIABETIC CARE CENTER	0	0	0	0	0	90.01	
90.02 04951 ANTI-COAGULATION CLINIC	0	1,378,419	0	0	0	90.02	
90.03 04952 PALLIATIVE CARE	0	0	0	0	0	90.03	
90.04 04953 SPINE CENTER	0	366,074	0	0	0	90.04	
91.00 09100 EMERGENCY	77	132,248,649	0	6,712	6,712	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	391	917,188,279	39,964	75,474	75,474	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
194.00 07950 HOME OFFICE	0	0	0	0	0	194.00	
194.06 07956 LEASED OFFICE SPACE	0	0	0	0	0	194.06	
194.08 07958 MISC NONREIMBURSABLE COST CENTERS	0	0	0	3,288	3,288	194.08	
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)	3,885,419	2,588,622	2,237,936	774,205	1,240,708	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9,937.132992	0.002822	55.998799	9.829677	15.752622	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	97,980	64,583	85,185	18,994	30,439	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1  
Date/Time Prepared:  
5/29/2019 3:00 pm

Cost Center Description	NURSING ADMINISTRATION  (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE  (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS			
				SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
				13.00	16.00		17.00
205.00	Unit cost multiplier (Wkst. B, Part II)	250.588235	0.000070	2.131543	0.241157	0.386468	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0128

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2019 3:00 pm

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	52,021,203		52,021,203	0	52,021,203	30.00
31.00	03100 INTENSIVE CARE UNIT	7,577,510		7,577,510	0	7,577,510	31.00
43.00	04300 NURSERY	1,849,616		1,849,616	0	1,849,616	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	11,808,530		11,808,530	0	11,808,530	50.00
51.00	05100 RECOVERY ROOM	5,630,366		5,630,366	0	5,630,366	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,990,905		4,990,905	0	4,990,905	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,918,006		3,918,006	0	3,918,006	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,565,774		1,565,774	0	1,565,774	55.00
57.00	05700 CT SCAN	2,470,676		2,470,676	0	2,470,676	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	760,579		760,579	0	760,579	58.00
59.00	05900 CARDIAC CATHETERIZATION	5,478,467		5,478,467	0	5,478,467	59.00
60.00	06000 LABORATORY	8,155,755		8,155,755	0	8,155,755	60.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	3,687,391	0	3,687,391	0	3,687,391	65.00
66.00	06600 PHYSICAL THERAPY	3,947,034	0	3,947,034	0	3,947,034	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,076,165	0	1,076,165	0	1,076,165	67.00
68.00	06800 SPEECH PATHOLOGY	272,694	0	272,694	0	272,694	68.00
69.00	06900 ELECTROCARDIOLOGY	2,456,915		2,456,915	0	2,456,915	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,389,675		1,389,675	0	1,389,675	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17,989,154		17,989,154	0	17,989,154	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13,512,033		13,512,033	0	13,512,033	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15,850,204		15,850,204	0	15,850,204	73.00
74.00	07400 RENAL DIALYSIS	620,530		620,530	0	620,530	74.00
76.00	03950 ENDOSCOPY	1,854,258		1,854,258	0	1,854,258	76.00
76.06	03330 IMAGING CENTER	2,406,541		2,406,541	0	2,406,541	76.06
76.97	07697 CARDIAC REHABILITATION	434,570		434,570	0	434,570	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0		0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0		0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	507,300		507,300	0	507,300	90.02
90.03	04952 PALLIATIVE CARE	0		0	0	0	90.03
90.04	04953 SPINE CENTER	347,147		347,147	0	347,147	90.04
91.00	09100 EMERGENCY	14,026,350		14,026,350	0	14,026,350	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6,135,739		6,135,739	0	6,135,739	92.00
200.00	Subtotal (see instructions)	192,741,087	0	192,741,087	0	192,741,087	200.00
201.00	Less Observation Beds	6,135,739		6,135,739	0	6,135,739	201.00
202.00	Total (see instructions)	186,605,348	0	186,605,348	0	186,605,348	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 3:00 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	108,150,968		108,150,968	30.00
31.00	03100	INTENSIVE CARE UNIT	10,142,635		10,142,635	31.00
43.00	04300	NURSERY	4,286,079		4,286,079	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	61,971,270	43,523,122	105,494,392	0.111935 50.00
51.00	05100	RECOVERY ROOM	12,659,493	21,958,076	34,617,569	0.162645 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,691,539	0	10,691,539	0.466809 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,496,892	25,651,881	33,148,773	0.118195 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,544,756	14,184,727	20,729,483	0.075534 55.00
57.00	05700	CT SCAN	15,324,040	44,420,947	59,744,987	0.041354 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,746,200	7,822,744	10,568,944	0.071964 58.00
59.00	05900	CARDIAC CATHETERIZATION	29,963,889	36,140,842	66,104,731	0.082876 59.00
60.00	06000	LABORATORY	44,234,890	35,399,003	79,633,893	0.102416 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000 64.00
65.00	06500	RESPIRATORY THERAPY	11,841,781	1,799,940	13,641,721	0.270302 65.00
66.00	06600	PHYSICAL THERAPY	3,608,155	6,498,659	10,106,814	0.390532 66.00
67.00	06700	OCCUPATIONAL THERAPY	2,337,841	944,304	3,282,145	0.327885 67.00
68.00	06800	SPEECH PATHOLOGY	662,537	167,002	829,539	0.328730 68.00
69.00	06900	ELECTROCARDIOLOGY	8,165,053	18,530,371	26,695,424	0.092035 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	291,363	4,476,722	4,768,085	0.291453 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,224,505	19,496,650	47,721,155	0.376964 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,901,933	12,265,739	35,167,672	0.384217 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,806,231	22,900,642	63,706,873	0.248799 73.00
74.00	07400	RENAL DIALYSIS	1,337,073	0	1,337,073	0.464096 74.00
76.00	03950	ENDOSCOPY	2,144,495	8,958,607	11,103,102	0.167004 76.00
76.06	03330	IMAGING CENTER	131,214	13,118,191	13,249,405	0.181634 76.06
76.97	07697	CARDIAC REHABILITATION	6,719	1,405,582	1,412,301	0.307704 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0	0.000000 90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0.000000 90.01
90.02	04951	ANTI-COAGULATION CLINIC	13,966	1,364,453	1,378,419	0.368030 90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0.000000 90.03
90.04	04953	SPINE CENTER	492	365,582	366,074	0.948297 90.04
91.00	09100	EMERGENCY	26,549,161	105,699,488	132,248,649	0.106060 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,310,999	5,548,836	6,859,835	0.894444 92.00
200.00		Subtotal (see instructions)	464,546,169	452,642,110	917,188,279	
201.00		Less Observation Beds				
202.00		Total (see instructions)	464,546,169	452,642,110	917,188,279	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 3:00 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.111935		50.00
51.00	05100 RECOVERY ROOM	0.162645		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.466809		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.118195		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.075534		55.00
57.00	05700 CT SCAN	0.041354		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.071964		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.082876		59.00
60.00	06000 LABORATORY	0.102416		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.270302		65.00
66.00	06600 PHYSICAL THERAPY	0.390532		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.327885		67.00
68.00	06800 SPEECH PATHOLOGY	0.328730		68.00
69.00	06900 ELECTROCARDIOLOGY	0.092035		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.291453		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376964		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.384217		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.248799		73.00
74.00	07400 RENAL DIALYSIS	0.464096		74.00
76.00	03950 ENDOSCOPY	0.167004		76.00
76.06	03330 IMAGING CENTER	0.181634		76.06
76.97	07697 CARDIAC REHABILITATION	0.307704		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
90.01	04950 DIABETIC CARE CENTER	0.000000		90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.368030		90.02
90.03	04952 PALLIATIVE CARE	0.000000		90.03
90.04	04953 SPINE CENTER	0.948297		90.04
91.00	09100 EMERGENCY	0.106060		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.894444		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0128

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2019 3:00 pm

		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	53,553,888		53,553,888	0	53,553,888	30.00
31.00	03100 INTENSIVE CARE UNIT	7,696,673		7,696,673	0	7,696,673	31.00
43.00	04300 NURSERY	1,849,616		1,849,616	0	1,849,616	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	11,873,023		11,873,023	0	11,873,023	50.00
51.00	05100 RECOVERY ROOM	5,630,366		5,630,366	0	5,630,366	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,990,905		4,990,905	0	4,990,905	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,939,035		3,939,035	0	3,939,035	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,565,774		1,565,774	0	1,565,774	55.00
57.00	05700 CT SCAN	2,470,676		2,470,676	0	2,470,676	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	760,579		760,579	0	760,579	58.00
59.00	05900 CARDIAC CATHETERIZATION	5,478,467		5,478,467	0	5,478,467	59.00
60.00	06000 LABORATORY	8,155,755		8,155,755	0	8,155,755	60.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	3,687,391	0	3,687,391	0	3,687,391	65.00
66.00	06600 PHYSICAL THERAPY	3,947,034	0	3,947,034	0	3,947,034	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,076,165	0	1,076,165	0	1,076,165	67.00
68.00	06800 SPEECH PATHOLOGY	272,694	0	272,694	0	272,694	68.00
69.00	06900 ELECTROCARDIOLOGY	2,456,915		2,456,915	0	2,456,915	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,411,394		1,411,394	0	1,411,394	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17,989,154		17,989,154	0	17,989,154	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13,512,033		13,512,033	0	13,512,033	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15,850,204		15,850,204	0	15,850,204	73.00
74.00	07400 RENAL DIALYSIS	620,530		620,530	0	620,530	74.00
76.00	03950 ENDOSCOPY	1,854,258		1,854,258	0	1,854,258	76.00
76.06	03330 IMAGING CENTER	2,406,541		2,406,541	0	2,406,541	76.06
76.97	07697 CARDIAC REHABILITATION	434,570		434,570	0	434,570	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0		0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0		0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	507,300		507,300	0	507,300	90.02
90.03	04952 PALLIATIVE CARE	0		0	0	0	90.03
90.04	04953 SPINE CENTER	347,147		347,147	0	347,147	90.04
91.00	09100 EMERGENCY	14,198,059		14,198,059	0	14,198,059	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6,135,739		6,135,739	0	6,135,739	92.00
200.00	Subtotal (see instructions)	194,671,885	0	194,671,885	0	194,671,885	200.00
201.00	Less Observation Beds	6,135,739		6,135,739	0	6,135,739	201.00
202.00	Total (see instructions)	188,536,146	0	188,536,146	0	188,536,146	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 3:00 pm
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		Title XIX			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	108,150,968		108,150,968		30.00
31.00	03100	INTENSIVE CARE UNIT	10,142,635		10,142,635		31.00
43.00	04300	NURSERY	4,286,079		4,286,079		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	61,971,270	43,523,122	105,494,392	0.112546	50.00
51.00	05100	RECOVERY ROOM	12,659,493	21,958,076	34,617,569	0.162645	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,691,539	0	10,691,539	0.466809	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,496,892	25,651,881	33,148,773	0.118829	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,544,756	14,184,727	20,729,483	0.075534	55.00
57.00	05700	CT SCAN	15,324,040	44,420,947	59,744,987	0.041354	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,746,200	7,822,744	10,568,944	0.071964	58.00
59.00	05900	CARDIAC CATHETERIZATION	29,963,889	36,140,842	66,104,731	0.082876	59.00
60.00	06000	LABORATORY	44,234,890	35,399,003	79,633,893	0.102416	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	11,841,781	1,799,940	13,641,721	0.270302	65.00
66.00	06600	PHYSICAL THERAPY	3,608,155	6,498,659	10,106,814	0.390532	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,337,841	944,304	3,282,145	0.327885	67.00
68.00	06800	SPEECH PATHOLOGY	662,537	167,002	829,539	0.328730	68.00
69.00	06900	ELECTROCARDIOLOGY	8,165,053	18,530,371	26,695,424	0.092035	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	291,363	4,476,722	4,768,085	0.296009	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,224,505	19,496,650	47,721,155	0.376964	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,901,933	12,265,739	35,167,672	0.384217	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,806,231	22,900,642	63,706,873	0.248799	73.00
74.00	07400	RENAL DIALYSIS	1,337,073	0	1,337,073	0.464096	74.00
76.00	03950	ENDOSCOPY	2,144,495	8,958,607	11,103,102	0.167004	76.00
76.06	03330	IMAGING CENTER	131,214	13,118,191	13,249,405	0.181634	76.06
76.97	07697	CARDIAC REHABILITATION	6,719	1,405,582	1,412,301	0.307704	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	13,966	1,364,453	1,378,419	0.368030	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	492	365,582	366,074	0.948297	90.04
91.00	09100	EMERGENCY	26,549,161	105,699,488	132,248,649	0.107359	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,310,999	5,548,836	6,859,835	0.894444	92.00
200.00		Subtotal (see instructions)	464,546,169	452,642,110	917,188,279		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	464,546,169	452,642,110	917,188,279		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 3:00 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.112546		50.00
51.00	05100 RECOVERY ROOM	0.162645		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.466809		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.118829		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.075534		55.00
57.00	05700 CT SCAN	0.041354		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.071964		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.082876		59.00
60.00	06000 LABORATORY	0.102416		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.270302		65.00
66.00	06600 PHYSICAL THERAPY	0.390532		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.327885		67.00
68.00	06800 SPEECH PATHOLOGY	0.328730		68.00
69.00	06900 ELECTROCARDIOLOGY	0.092035		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.296009		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376964		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.384217		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.248799		73.00
74.00	07400 RENAL DIALYSIS	0.464096		74.00
76.00	03950 ENDOSCOPY	0.167004		76.00
76.06	03330 IMAGING CENTER	0.181634		76.06
76.97	07697 CARDIAC REHABILITATION	0.307704		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
90.01	04950 DIABETIC CARE CENTER	0.000000		90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.368030		90.02
90.03	04952 PALLIATIVE CARE	0.000000		90.03
90.04	04953 SPINE CENTER	0.948297		90.04
91.00	09100 EMERGENCY	0.107359		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.894444		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00



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

Provider CCN: 15-0128

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

Worksheet C Part II Date/Time Prepared: 5/29/2019 3:00 pm

Cost Center Description		Title XIX			Hospital	PPS		
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	11,873,023	1,938,602	9,934,421	0	0	50.00
51.00	05100	RECOVERY ROOM	5,630,366	365,030	5,265,336	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,990,905	384,225	4,606,680	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,939,035	659,395	3,279,640	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,565,774	144,409	1,421,365	0	0	55.00
57.00	05700	CT SCAN	2,470,676	363,783	2,106,893	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	760,579	66,729	693,850	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,478,467	1,128,663	4,349,804	0	0	59.00
60.00	06000	LABORATORY	8,155,755	306,796	7,848,959	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,687,391	223,651	3,463,740	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,947,034	657,295	3,289,739	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,076,165	66,325	1,009,840	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	272,694	16,920	255,774	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,456,915	257,447	2,199,468	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,411,394	203,516	1,207,878	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,989,154	1,409,034	16,580,120	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,512,033	331,521	13,180,512	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,850,204	794,107	15,056,097	0	0	73.00
74.00	07400	RENAL DIALYSIS	620,530	40,371	580,159	0	0	74.00
76.00	03950	ENDOSCOPY	1,854,258	343,941	1,510,317	0	0	76.00
76.06	03330	IMAGING CENTER	2,406,541	451,466	1,955,075	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	434,570	17,841	416,729	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	507,300	16,005	491,295	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPIRE CENTER	347,147	54,233	292,914	0	0	90.04
91.00	09100	EMERGENCY	14,198,059	1,067,267	13,130,792	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,135,739	461,481	5,674,258	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	131,571,708	11,770,053	119,801,655	0	0	200.00
201.00		Less Observation Beds	6,135,739	461,481	5,674,258	0	0	201.00
202.00		Total (line 200 minus line 201)	125,435,969	11,308,572	114,127,397	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part II Date/Time Prepared: 5/29/2019 3:00 pm
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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	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	11,873,023	105,494,392	0.112546	50.00
51.00	05100 RECOVERY ROOM	5,630,366	34,617,569	0.162645	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,990,905	10,691,539	0.466809	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,939,035	33,148,773	0.118829	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,565,774	20,729,483	0.075534	55.00
57.00	05700 CT SCAN	2,470,676	59,744,987	0.041354	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	760,579	10,568,944	0.071964	58.00
59.00	05900 CARDIAC CATHETERIZATION	5,478,467	66,104,731	0.082876	59.00
60.00	06000 LABORATORY	8,155,755	79,633,893	0.102416	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	3,687,391	13,641,721	0.270302	65.00
66.00	06600 PHYSICAL THERAPY	3,947,034	10,106,814	0.390532	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,076,165	3,282,145	0.327885	67.00
68.00	06800 SPEECH PATHOLOGY	272,694	829,539	0.328730	68.00
69.00	06900 ELECTROCARDIOLOGY	2,456,915	26,695,424	0.092035	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,411,394	4,768,085	0.296009	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17,989,154	47,721,155	0.376964	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13,512,033	35,167,672	0.384217	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15,850,204	63,706,873	0.248799	73.00
74.00	07400 RENAL DIALYSIS	620,530	1,337,073	0.464096	74.00
76.00	03950 ENDOSCOPY	1,854,258	11,103,102	0.167004	76.00
76.06	03330 IMAGING CENTER	2,406,541	13,249,405	0.181634	76.06
76.97	07697 CARDIAC REHABILITATION	434,570	1,412,301	0.307704	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0.000000	90.00
90.01	04950 DIABETIC CARE CENTER	0	0	0.000000	90.01
90.02	04951 ANTI-COAGULATION CLINIC	507,300	1,378,419	0.368030	90.02
90.03	04952 PALLIATIVE CARE	0	0	0.000000	90.03
90.04	04953 SPINE CENTER	347,147	366,074	0.948297	90.04
91.00	09100 EMERGENCY	14,198,059	132,248,649	0.107359	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6,135,739	6,859,835	0.894444	92.00
200.00	Subtotal (sum of lines 50 thru 199)	131,571,708	794,608,597		200.00
201.00	Less Observation Beds	6,135,739	0		201.00
202.00	Total (line 200 minus line 201)	125,435,969	794,608,597		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0128		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part I Date/Time Prepared: 5/29/2019 3:00 pm	
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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	3,912,607	0	3,912,607	38,424	101.83	30.00
31.00	INTENSIVE CARE UNIT	1,007,621		1,007,621	2,888	348.90	31.00
43.00	NURSERY	147,588		147,588	3,184	46.35	43.00
200.00	Total (Lines 30 through 199)	5,067,816		5,067,816	44,496		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	12,279	1,250,371				
31.00	INTENSIVE CARE UNIT	945	329,711				
43.00	NURSERY	0	0				
200.00	Total (Lines 30 through 199)	13,224	1,580,082				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/29/2019 3:00 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,938,602	105,494,392	0.018376	22,935,439	421,462	50.00
51.00	05100	RECOVERY ROOM	365,030	34,617,569	0.010545	3,733,036	39,365	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	384,225	10,691,539	0.035937	20,431	734	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	659,395	33,148,773	0.019892	3,115,049	61,965	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	144,409	20,729,483	0.006966	3,109,008	21,657	55.00
57.00	05700	CT SCAN	363,783	59,744,987	0.006089	6,278,351	38,229	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	66,729	10,568,944	0.006314	1,030,010	6,503	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,128,663	66,104,731	0.017074	11,791,719	201,332	59.00
60.00	06000	LABORATORY	306,796	79,633,893	0.003853	17,668,878	68,078	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	223,651	13,641,721	0.016395	3,983,468	65,309	65.00
66.00	06600	PHYSICAL THERAPY	657,295	10,106,814	0.065035	1,595,614	103,771	66.00
67.00	06700	OCCUPATIONAL THERAPY	66,325	3,282,145	0.020208	1,092,550	22,078	67.00
68.00	06800	SPEECH PATHOLOGY	16,920	829,539	0.020397	324,392	6,617	68.00
69.00	06900	ELECTROCARDIOLOGY	257,447	26,695,424	0.009644	4,103,856	39,578	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	203,516	4,768,085	0.042683	118,456	5,056	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,409,034	47,721,155	0.029526	9,629,779	284,329	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	331,521	35,167,672	0.009427	9,296,733	87,640	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	794,107	63,706,873	0.012465	13,782,481	171,799	73.00
74.00	07400	RENAL DIALYSIS	40,371	1,337,073	0.030194	721,494	21,785	74.00
76.00	03950	ENDOSCOPY	343,941	11,103,102	0.030977	33,682	1,043	76.00
76.06	03330	IMAGING CENTER	451,466	13,249,405	0.034074	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	17,841	1,412,301	0.012633	867	11	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	16,005	1,378,419	0.011611	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	54,233	366,074	0.148148	0	0	90.04
91.00	09100	EMERGENCY	1,067,267	132,248,649	0.008070	11,399,481	91,994	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	461,481	6,859,835	0.067273	462,795	31,134	92.00
200.00		Total (lines 50 through 199)	11,770,053	794,608,597		126,227,569	1,791,469	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0128		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part III Date/Time Prepared: 5/29/2019 3:00 pm			
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	
43.00	04300	NURSERY	0	0	0	0	0		43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0		200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	38,424	0.00	12,279		30.00	
31.00	03100	INTENSIVE CARE UNIT		0	2,888	0.00	945		31.00	
43.00	04300	NURSERY		0	3,184	0.00	0		43.00	
200.00		Total (lines 30 through 199)		0	44,496		13,224		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
43.00	04300	NURSERY						0		43.00
200.00		Total (lines 30 through 199)						0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:00 pm
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Cost Center Description	Title XVIII				Hospital		PPS
	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		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:00 pm
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Cost Center Description		Title XVIII				Hospital	PPS	
		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	105,494,392	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	34,617,569	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,691,539	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,148,773	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,729,483	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	59,744,987	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	10,568,944	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	66,104,731	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	79,633,893	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,641,721	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,106,814	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,282,145	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	829,539	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	26,695,424	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,768,085	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	47,721,155	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,167,672	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	63,706,873	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,337,073	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	11,103,102	0.000000	76.00
76.06	03330	IMAGING CENTER	0	0	0	13,249,405	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,412,301	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	1,378,419	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	0	0	0	366,074	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	132,248,649	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	6,859,835	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	794,608,597		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:00 pm
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Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	22,935,439	0	8,803,591	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	3,733,036	0	5,074,675	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	20,431	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	3,115,049	0	6,386,102	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	3,109,008	0	7,363,410	0	55.00
57.00	05700 CT SCAN	0.000000	6,278,351	0	9,844,097	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	1,030,010	0	2,066,983	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	11,791,719	0	13,003,638	0	59.00
60.00	06000 LABORATORY	0.000000	17,668,878	0	6,724,117	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	3,983,468	0	280,379	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,595,614	0	93,796	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,092,550	0	49,991	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	324,392	0	7,375	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	4,103,856	0	5,693,483	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	118,456	0	957,107	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	9,629,779	0	4,813,633	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	9,296,733	0	4,822,628	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	13,782,481	0	7,160,891	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	721,494	0	0	0	74.00
76.00	03950 ENDOSCOPY	0.000000	33,682	0	3,006,221	0	76.00
76.06	03330 IMAGING CENTER	0.000000	0	0	3,148,054	0	76.06
76.97	07697 CARDIAC REHABILITATION	0.000000	867	0	627,885	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.000000	0	0	674,867	0	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953 SPINE CENTER	0.000000	0	0	7,394	0	90.04
91.00	09100 EMERGENCY	0.000000	11,399,481	0	14,319,882	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	462,795	0	3,082,459	0	92.00
200.00	Total (lines 50 through 199)		126,227,569	0	108,012,658	0	200.00



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 3:00 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.111935	8,803,591	0	0	985,430	50.00
51.00	05100	RECOVERY ROOM	0.162645	5,074,675	0	0	825,371	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.466809	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.118195	6,386,102	0	0	754,805	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.075534	7,363,410	0	0	556,188	55.00
57.00	05700	CT SCAN	0.041354	9,844,097	0	0	407,093	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071964	2,066,983	0	0	148,748	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.082876	13,003,638	0	0	1,077,690	59.00
60.00	06000	LABORATORY	0.102416	6,724,117	0	0	688,657	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.270302	280,379	0	0	75,787	65.00
66.00	06600	PHYSICAL THERAPY	0.390532	93,796	0	0	36,630	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.327885	49,991	0	0	16,391	67.00
68.00	06800	SPEECH PATHOLOGY	0.328730	7,375	0	0	2,424	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092035	5,693,483	0	0	524,000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.291453	957,107	0	0	278,952	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376964	4,813,633	0	0	1,814,566	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.384217	4,822,628	0	0	1,852,936	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.248799	7,160,891	0	147,708	1,781,623	73.00
74.00	07400	RENAL DIALYSIS	0.464096	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.167004	3,006,221	0	0	502,051	76.00
76.06	03330	IMAGING CENTER	0.181634	3,148,054	0	0	571,794	76.06
76.97	07697	CARDIAC REHABILITATION	0.307704	627,885	0	0	193,203	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.368030	674,867	0	0	248,371	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPIRE CENTER	0.948297	7,394	0	0	7,012	90.04
91.00	09100	EMERGENCY	0.106060	14,319,882	0	0	1,518,767	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.894444	3,082,459	0	0	2,757,087	92.00
200.00		Subtotal (see instructions)		108,012,658	0	147,708	17,625,576	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		108,012,658	0	147,708	17,625,576	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 3:00 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	36,750	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	90.03
90.04	04953	SPINE CENTER	0	0	90.04
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	36,750	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	36,750	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0128		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part I Date/Time Prepared: 5/29/2019 3:00 pm		
Cost Center Description		Title XIX		Hospital		PPS		
		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	3,912,607	0	3,912,607	38,424	101.83	30.00	
31.00	INTENSIVE CARE UNIT	1,007,621		1,007,621	2,888	348.90	31.00	
43.00	NURSERY	147,588		147,588	3,184	46.35	43.00	
200.00	Total (Lines 30 through 199)	5,067,816		5,067,816	44,496		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	811	82,584					30.00
31.00	INTENSIVE CARE UNIT	0	0					31.00
43.00	NURSERY	1,550	71,843					43.00
200.00	Total (Lines 30 through 199)	2,361	154,427					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/29/2019 3:00 pm
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Cost Center Description		Title XIX			Hospital	PPS		
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,938,602	105,494,392	0.018376	513,591	9,438	50.00
51.00	05100	RECOVERY ROOM	365,030	34,617,569	0.010545	141,509	1,492	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	384,225	10,691,539	0.035937	192,206	6,907	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	659,395	33,148,773	0.019892	122,250	2,432	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	144,409	20,729,483	0.006966	71,086	495	55.00
57.00	05700	CT SCAN	363,783	59,744,987	0.006089	271,084	1,651	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	66,729	10,568,944	0.006314	37,594	237	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,128,663	66,104,731	0.017074	339,891	5,803	59.00
60.00	06000	LABORATORY	306,796	79,633,893	0.003853	815,330	3,141	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	223,651	13,641,721	0.016395	276,825	4,539	65.00
66.00	06600	PHYSICAL THERAPY	657,295	10,106,814	0.065035	54,520	3,546	66.00
67.00	06700	OCCUPATIONAL THERAPY	66,325	3,282,145	0.020208	33,670	680	67.00
68.00	06800	SPEECH PATHOLOGY	16,920	829,539	0.020397	22,385	457	68.00
69.00	06900	ELECTROCARDIOLOGY	257,447	26,695,424	0.009644	101,060	975	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	203,516	4,768,085	0.042683	10,725	458	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,409,034	47,721,155	0.029526	595,155	17,573	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	331,521	35,167,672	0.009427	296,997	2,800	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	794,107	63,706,873	0.012465	942,297	11,746	73.00
74.00	07400	RENAL DIALYSIS	40,371	1,337,073	0.030194	23,532	711	74.00
76.00	03950	ENDOSCOPY	343,941	11,103,102	0.030977	30,033	930	76.00
76.06	03330	IMAGING CENTER	451,466	13,249,405	0.034074	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	17,841	1,412,301	0.012633	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	16,005	1,378,419	0.011611	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	54,233	366,074	0.148148	0	0	90.04
91.00	09100	EMERGENCY	1,067,267	132,248,649	0.008070	478,551	3,862	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	461,479	6,859,835	0.067273	14,660	986	92.00
200.00		Total (lines 50 through 199)	11,770,051	794,608,597		5,384,951	80,859	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Prepared: 5/29/2019 3:00 pm
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Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
		1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	200.00	
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
		4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	38,424	0.00	811 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	2,888	0.00	0 31.00	
43.00	04300	NURSERY	0	0	3,184	0.00	1,550 43.00	
200.00		Total (lines 30 through 199)	0	0	44,496	2,361	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
43.00	04300	NURSERY	0					43.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:00 pm
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Cost Center Description	Title XIX				Hospital		PPS
	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		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:00 pm
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Cost Center Description		Title XIX				Hospital	PPS	
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	105,494,392	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	34,617,569	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,691,539	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,148,773	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,729,483	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	59,744,987	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	10,568,944	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	66,104,731	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	79,633,893	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,641,721	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,106,814	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,282,145	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	829,539	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	26,695,424	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,768,085	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	47,721,155	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,167,672	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	63,706,873	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,337,073	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	11,103,102	0.000000	76.00
76.06	03330	IMAGING CENTER	0	0	0	13,249,405	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,412,301	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	1,378,419	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	0	0	0	366,074	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	132,248,649	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	6,859,835	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	794,608,597		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:00 pm
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Cost Center Description		Title XIX			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	513,591	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	141,509	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	192,206	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	122,250	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	71,086	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	271,084	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	37,594	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	339,891	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	815,330	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	276,825	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	54,520	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	33,670	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	22,385	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	101,060	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	10,725	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	595,155	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	296,997	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	942,297	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	23,532	0	0	0	74.00
76.00	03950 ENDOSCOPY	0.000000	30,033	0	0	0	76.00
76.06	03330 IMAGING CENTER	0.000000	0	0	0	0	76.06
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.000000	0	0	0	0	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953 SPINE CENTER	0.000000	0	0	0	0	90.04
91.00	09100 EMERGENCY	0.000000	478,551	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	14,660	0	0	0	92.00
200.00	Total (lines 50 through 199)		5,384,951	0	0	0	200.00



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 3:00 pm
		Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.112546	0	265,490	0	0	50.00
51.00	05100 RECOVERY ROOM	0.162645	0	102,034	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.466809	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.118829	0	427,554	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.075534	0	110,838	0	0	55.00
57.00	05700 CT SCAN	0.041354	0	596,501	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.071964	0	101,636	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.082876	0	226,507	0	0	59.00
60.00	06000 LABORATORY	0.102416	0	678,222	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.270302	0	25,235	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.390532	0	65,933	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.327885	0	12,534	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.328730	0	8,855	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.092035	0	104,779	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.296009	0	26,744	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376964	0	174,040	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.384217	0	86,051	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.248799	0	143,250	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.464096	0	0	0	0	74.00
76.00	03950 ENDOSCOPY	0.167004	0	54,805	0	0	76.00
76.06	03330 IMAGING CENTER	0.181634	0	66,926	0	0	76.06
76.97	07697 CARDIAC REHABILITATION	0.307704	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.368030	0	8,070	0	0	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953 SPIRE CENTER	0.948297	0	0	0	0	90.04
91.00	09100 EMERGENCY	0.107359	0	2,496,830	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.894444	0	69,534	0	0	92.00
200.00	Subtotal (see instructions)		0	5,852,368	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	5,852,368	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 3:00 pm
		Title XIX	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	29,880	0	50.00
51.00	05100 RECOVERY ROOM	16,595	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	50,806	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	8,372	0	55.00
57.00	05700 CT SCAN	24,668	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	7,314	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	18,772	0	59.00
60.00	06000 LABORATORY	69,461	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	6,821	0	65.00
66.00	06600 PHYSICAL THERAPY	25,749	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,110	0	67.00
68.00	06800 SPEECH PATHOLOGY	2,911	0	68.00
69.00	06900 ELECTROCARDIOLOGY	9,643	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	7,916	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	65,607	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	33,062	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	35,640	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 ENDOSCOPY	9,153	0	76.00
76.06	03330 IMAGING CENTER	12,156	0	76.06
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	2,970	0	90.02
90.03	04952 PALLIATIVE CARE	0	0	90.03
90.04	04953 SPINE CENTER	0	0	90.04
91.00	09100 EMERGENCY	268,057	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	62,194	0	92.00
200.00	Subtotal (see instructions)	771,857	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	771,857	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2019 3:00 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		38,424	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		38,424	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)		33,892	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)		12,279	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
<b>SWING BED ADJUSTMENT</b>				
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)		52,021,203	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)		52,021,203	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		52,021,203	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,353.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		16,624,170	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)		16,624,170	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/29/2019 3:00 pm	
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)	
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	7,577,510	2,888	2,623.79	945	2,479,482	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					22,079,364	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					41,183,016	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,580,082	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,791,469	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					3,371,551	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					37,811,465	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					4,532	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,353.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					6,135,739	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/29/2019 3:00 pm	
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	3,912,607	52,021,203	0.075212	6,135,739	461,481	90.00
91.00	Nursing School cost	0	52,021,203	0.000000	6,135,739	0	91.00
92.00	Allied health cost	0	52,021,203	0.000000	6,135,739	0	92.00
93.00	All other Medical Education	0	52,021,203	0.000000	6,135,739	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2019 3:00 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		38,424	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		38,424	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)		33,892	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)		811	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)		3,184	15.00
16.00	Nursery days (title V or XIX only)		1,550	16.00
<b>SWING BED ADJUSTMENT</b>				
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)		53,553,888	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)		53,553,888	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		53,553,888	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,393.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,130,339	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,130,339	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 3:00 pm	
Cost Center Description			Title XIX		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	1.00	2.00	3.00	4.00	5.00	
NURSERY (title V & XIX only)						
	1,849,616	3,184	580.91	1,550	900,411	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	7,696,673	2,888	2,665.05	0	0	43.00
44.00						44.00
45.00						45.00
46.00						46.00
47.00						47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				1,096,351	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				3,127,101	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)				154,427	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				80,859	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				235,286	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				2,891,815	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				4,532	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,393.76	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				6,316,520	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/29/2019 3:00 pm	
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	3,912,607	53,553,888	0.073059	6,316,520	461,479	90.00
91.00	Nursing School cost	0	53,553,888	0.000000	6,316,520	0	91.00
92.00	Allied health cost	0	53,553,888	0.000000	6,316,520	0	92.00
93.00	All other Medical Education	0	53,553,888	0.000000	6,316,520	0	93.00



INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/29/2019 3:00 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		25,035,981		30.00
31.00	03100 INTENSIVE CARE UNIT		3,220,485		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.111935	22,935,439	2,567,278	50.00
51.00	05100 RECOVERY ROOM	0.162645	3,733,036	607,160	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.466809	20,431	9,537	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.118195	3,115,049	368,183	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.075534	3,109,008	234,836	55.00
57.00	05700 CT SCAN	0.041354	6,278,351	259,635	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.071964	1,030,010	74,124	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.082876	11,791,719	977,251	59.00
60.00	06000 LABORATORY	0.102416	17,668,878	1,809,576	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.270302	3,983,468	1,076,739	65.00
66.00	06600 PHYSICAL THERAPY	0.390532	1,595,614	623,138	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.327885	1,092,550	358,231	67.00
68.00	06800 SPEECH PATHOLOGY	0.328730	324,392	106,637	68.00
69.00	06900 ELECTROCARDIOLOGY	0.092035	4,103,856	377,698	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.291453	118,456	34,524	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376964	9,629,779	3,630,080	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.384217	9,296,733	3,571,963	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.248799	13,782,481	3,429,067	73.00
74.00	07400 RENAL DIALYSIS	0.464096	721,494	334,842	74.00
76.00	03950 ENDOSCOPY	0.167004	33,682	5,625	76.00
76.06	03330 IMAGING CENTER	0.181634	0	0	76.06
76.97	07697 CARDIAC REHABILITATION	0.307704	867	267	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.368030	0	0	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	90.03
90.04	04953 SPINE CENTER	0.948297	0	0	90.04
91.00	09100 EMERGENCY	0.106060	11,399,481	1,209,029	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.894444	462,795	413,944	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		126,227,569	22,079,364	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		126,227,569		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/29/2019 3:00 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		2,308,533		30.00
31.00	03100 INTENSIVE CARE UNIT		344,283		31.00
43.00	04300 NURSERY		145,203		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.112546	513,591	57,803	50.00
51.00	05100 RECOVERY ROOM	0.162645	141,509	23,016	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.466809	192,206	89,723	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.118829	122,250	14,527	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.075534	71,086	5,369	55.00
57.00	05700 CT SCAN	0.041354	271,084	11,210	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.071964	37,594	2,705	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.082876	339,891	28,169	59.00
60.00	06000 LABORATORY	0.102416	815,330	83,503	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.270302	276,825	74,826	65.00
66.00	06600 PHYSICAL THERAPY	0.390532	54,520	21,292	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.327885	33,670	11,040	67.00
68.00	06800 SPEECH PATHOLOGY	0.328730	22,385	7,359	68.00
69.00	06900 ELECTROCARDIOLOGY	0.092035	101,060	9,301	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.296009	10,725	3,175	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376964	595,155	224,352	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.384217	296,997	114,111	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.248799	942,297	234,443	73.00
74.00	07400 RENAL DIALYSIS	0.464096	23,532	10,921	74.00
76.00	03950 ENDOSCOPY	0.167004	30,033	5,016	76.00
76.06	03330 IMAGING CENTER	0.181634	0	0	76.06
76.97	07697 CARDIAC REHABILITATION	0.307704	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.368030	0	0	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	90.03
90.04	04953 SPINE CENTER	0.948297	0	0	90.04
91.00	09100 EMERGENCY	0.107359	478,551	51,377	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.894444	14,660	13,113	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,384,951	1,096,351	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		5,384,951		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 3:00 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
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)		21,592,960	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		7,479,426	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)		870,671	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		11,866,205	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		155.14	4.00
<b>Indirect Medical Education Adjustment</b>				
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).		6.09	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)		6.09	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		6.42	10.00
11.00	FTE count for residents in dental and podiatric programs.		1.45	11.00
12.00	Current year allowable FTE (see instructions)		7.54	12.00
13.00	Total allowable FTE count for the prior year.		6.88	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.		3.80	14.00
15.00	Sum of lines 12 through 14 divided by 3.		6.07	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		6.07	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.039126	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.044043	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.039126	21.00
22.00	IME payment adjustment (see instructions)		614,823	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		250,947	22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
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)		0.33	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)		614,823	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		250,947	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.49	30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.75	31.00
32.00	Sum of lines 30 and 31		25.24	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.04	33.00
34.00	Disproportionate share adjustment (see instructions)		729,717	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 3:00 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>Uncompensated Care Adjustment</b>				
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000196574	0.000193416	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,330,154	1,600,102	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	994,882	403,314	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,398,196		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)	32,685,793		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
				<b>Amount</b>
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		32,936,740	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,626,098	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).		178,996	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 instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		35,741,834	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		35,741,834	61.00
62.00	Deductibles billed to program beneficiaries		3,168,308	62.00
63.00	Coinurance billed to program beneficiaries		49,580	63.00
64.00	Allowable bad debts (see instructions)		180,418	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		117,272	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		57,157	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		32,641,218	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-150,608	70.93
70.94	HRR adjustment amount (see instructions)		-173,446	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 3:00 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)		32,317,164	71.00
71.01	Sequestration adjustment (see instructions)		646,343	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		31,030,723	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)		640,098	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		348,099	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>				
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
<b>HSP Bonus Payment Amount</b>				
100.00	HSP bonus amount (see instructions)		0	100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
<b>Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment</b>				
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
<b>Cost Reimbursement</b>				
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
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>				
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
<b>Adjustment to Medicare Part A Inpatient Reimbursement</b>				
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
<b>Comparison of PPS versus Cost Reimbursement</b>				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 3:00 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		36,750	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		17,625,576	2.00
3.00	OPPS payments		15,776,809	3.00
4.00	Outlier payment (see instructions)		71,300	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)		36,750	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		147,708	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)		147,708	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		147,708	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		110,958	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)		36,750	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)		15,848,109	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,754,207	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)		13,130,652	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		76,752	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)		13,207,404	30.00
31.00	Primary payer payments		3,486	31.00
32.00	Subtotal (line 30 minus line 31)		13,203,918	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		283,250	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		184,113	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		241,774	36.00
37.00	Subtotal (see instructions)		13,388,031	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-118	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	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)		72,275	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		13,388,149	40.00
40.01	Sequestration adjustment (see instructions)		267,763	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		13,080,173	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		40,213	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 15-0128

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/29/2019 3:00 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		31,030,723		13,080,173	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		31,030,723		13,080,173	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		640,098		40,213	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		31,670,821		13,120,386	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: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/29/2019 3:00 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



DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet E-4 Date/Time Prepared: 5/29/2019 3:00 pm	
		Title XVIII	Hospital	PPS	
				1.00	
<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			6.09	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			6.09	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			6.42	6.00
7.00	Enter the lesser of line 5 or line 6			6.09	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	5.75	0.67	6.42	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	5.45	0.64	6.09	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		1.45		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		1.45		10.01
11.00	Total weighted FTE count	5.45	2.09		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	5.01	1.67		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	2.13	1.22		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	4.20	1.66		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	4.20	1.66		17.00
18.00	Per resident amount	90,337.76	90,337.76		18.00
19.00	Approved amount for resident costs	379,419	149,961	529,380	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.33	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			529,380	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>					
26.00	Inpatient Days (see instructions)	13,224	5,643		26.00
27.00	Total Inpatient Days (see instructions)	37,403	37,403		27.00
28.00	Ratio of inpatient days to total inpatient days	0.353555	0.150870		28.00
29.00	Program direct GME amount	187,165	79,868		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		11,285		30.00
31.00	Net Program direct GME amount			255,748	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet E-4 Date/Time Prepared: 5/29/2019 3:00 pm
		Title XVIII	Hospital	PPS
				1.00
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		1,337,073	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>				
<b>Part A Reasonable Cost</b>				
37.00	Reasonable cost (see instructions)		41,183,016	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		41,183,016	41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)		17,662,326	42.00
43.00	Primary payer payments (see instructions)		3,486	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		17,658,840	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		58,841,856	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.699893	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.300107	47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)		255,748	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		178,996	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		76,752	50.00

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

Provider CCN: 15-0128

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

Worksheet G

Date/Time Prepared:  
5/29/2019 3:00 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	6,099	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	191,738,113	0	0	0	4.00
5.00	Other receivable	-153,052,809	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	213,193	0	0	0	6.00
7.00	Inventory	3,877,376	0	0	0	7.00
8.00	Prepaid expenses	9,975	0	0	0	8.00
9.00	Other current assets	0	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)	42,791,947	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	1,254,312	0	0	0	12.00
13.00	Land improvements	2,722,362	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	177,055,544	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,737,035	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	76,709,244	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	53,839	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	-127,939,698	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	115,657	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	131,708,295	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	365,794,488	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	365,794,488	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	540,294,730	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	850,793	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,138,315	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,989,108	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	1,989,108	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	538,305,622	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	538,305,622	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	540,294,730	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0128

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

Worksheet G-1

Date/Time Prepared:  
5/29/2019 3:00 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		470,232,263		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		68,073,357			2.00
3.00	Total (sum of line 1 and line 2)		538,305,620		0	3.00
4.00	ROUNDING	2		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		2		0	10.00
11.00	Subtotal (line 3 plus line 10)		538,305,622		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		538,305,622		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0128

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/29/2019 3:00 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	109,142,345		109,142,345	1.00
2.00	SUBPROVIDER - IPF				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				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)	109,142,345		109,142,345	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	10,872,967		10,872,967	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	10,872,967		10,872,967	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	120,015,312		120,015,312	17.00
18.00	Ancillary services	330,646,792	483,230,254	813,877,046	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	76,175	76,175	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	450,662,104	483,306,429	933,968,533	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		203,651,124		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)		203,651,124		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0128

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

Worksheet G-3

Date/Time Prepared:  
5/29/2019 3:00 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	933,968,533	1.00
2.00	Less contractual allowances and discounts on patients' accounts	665,662,310	2.00
3.00	Net patient revenues (line 1 minus line 2)	268,306,223	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	203,651,124	4.00
5.00	Net income from service to patients (line 3 minus line 4)	64,655,099	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	3,351	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	12,834	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	1,265,229	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	541,098	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	1,595,746	24.00
25.00	Total other income (sum of lines 6-24)	3,418,258	25.00
26.00	Total (line 5 plus line 25)	68,073,357	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)	68,073,357	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/29/2019 3:00 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		2,367,510	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		95,229	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)		103.83	3.00
4.00	Number of interns & residents (see instructions)		6.07	4.00
5.00	Indirect medical education percentage (see instructions)		1.66	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)		39,301	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.49	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		22.75	8.00
9.00	Sum of lines 7 and 8		25.24	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.24	10.00
11.00	Disproportionate share adjustment (see instructions)		124,058	11.00
12.00	Total prospective capital payments (see instructions)		2,626,098	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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