This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0047	Period: From 06/01/2018 To 05/31/2019	Worksheet S Parts I-III Date/Time Prepared: 10/30/2019 3:37 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 10/30/2019 Time: 3:37 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST JOSEPH MEDICAL CENTER (15-0047) for the cost reporting period beginning 06/01/2018 and ending 05/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	346,817	-83,291	0	0	1.00
2.00	Subprovider - IPF	0	845	-372		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	347,662	-83,663	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 10/30/2019 3:37 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 700 BROADWAY STREET	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46802	County: ALLEN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST JOSEPH MEDICAL CENTER	150047	23060	1	07/01/1996	N	P	P	3.00
4.00	Subprovider - IPF	ST JOSPEH GENERATIONS	15S047	23060	4	06/01/2003	N	P	P	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	SKILLED NURSING FACILITY ST JOSEPH	155356	23060		04/01/1990	N	P	P	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	06/01/2018	05/31/2019	20.00
21.00	Type of Control (see instructions)	4		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,666	905	22	10	4,721	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 10/30/2019 3:37 pm

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 10/30/2019 3:37 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 10/30/2019 3:37 pm

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 10/30/2019 3:37 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	252,874	-17,872	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 10/30/2019 3:37 pm

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

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	06/01/2018	05/31/2019	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 10/30/2019 3:37 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	09/10/2019	Y	09/10/2019	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 10/30/2019 3:37 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2017	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 10/30/2019 3:37 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 10/30/2019 3:37 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	76	34,105	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)		76	34,105	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	12	4,380	0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		88	38,485	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	19	6,935		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	20	7,300		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		127				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: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 10/30/2019 3:37 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)	2,754	832	14,272			1.00
2.00	HMO and other (see instructions)	2,432	6,355				2.00
3.00	HMO IPF Subprovider	1,699	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,754	832	14,272			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	458	137	2,524			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)	3,212	969	16,796	0.50	402.96	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,882	544	5,300	0.00	26.85	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	1,695	279	4,623	0.00	14.48	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)			19			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.50	444.29	27.00
28.00	Observation Bed Days		0	1,635			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			51			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 10/30/2019 3:37 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	645	1,694	3,901	1.00
2.00	HMO and other (see instructions)			442	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
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	645	1,694	3,901	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	224	112	415	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-3 Part II Date/Time Prepared: 10/30/2019 3:37 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	28,460,672	0	28,460,672	924,125.00	30.80	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,071,481	0	1,071,481	30,118.00	35.58	9.00
10.00	Excluded area salaries (see instructions)		1,542,117	0	1,542,117	55,847.00	27.61	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		842,173	0	842,173	11,336.00	74.29	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		2,087,330	0	2,087,330	31,485.00	66.30	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		2,746,691	0	2,746,691	88,540.00	31.02	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,544,744	0	5,544,744			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		580,614	0	580,614			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		509,004	0	509,004			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	284,206	0	284,206	8,098.00	35.10	26.00
27.00	Administrative & General	5.00	3,503,007	-210,113	3,292,894	119,174.00	27.63	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-3 Part II | Date/Time Prepared: 10/30/2019 3:37 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,064,243	0	1,064,243	45,734.00	23.27	30.00
31.00	Laundry & Linen Service	8.00	1,114	0	1,114	56.00	19.89	31.00
32.00	Housekeeping	9.00	628,059	0	628,059	43,882.00	14.31	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		724,896	0	724,896	38,566.00	18.80	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,662,335	210,113	1,872,448	44,086.00	42.47	38.00
39.00	Central Services and Supply	14.00	222,127	0	222,127	9,907.00	22.42	39.00
40.00	Pharmacy	15.00	1,437,960	0	1,437,960	30,590.00	47.01	40.00
41.00	Medical Records & Medical Records Library	16.00	138,109	0	138,109	6,945.00	19.89	41.00
42.00	Social Service	17.00	789,392	0	789,392	21,981.00	35.91	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-3 Part III Date/Time Prepared: 10/30/2019 3:37 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		29,185,568	0	29,185,568	962,691.00	30.32	1.00
2.00	Excluded area salaries (see instructions)		2,613,598	0	2,613,598	85,965.00	30.40	2.00
3.00	Subtotal salaries (line 1 minus line 2)		26,571,970	0	26,571,970	876,726.00	30.31	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,676,194	0	5,676,194	131,361.00	43.21	4.00
5.00	Subtotal wage-related costs (see inst.)		6,053,748	0	6,053,748	0.00	22.78	5.00
6.00	Total (sum of lines 3 thru 5)		38,301,912	0	38,301,912	1,008,087.00	37.99	6.00
7.00	Total overhead cost (see instructions)		10,455,448	0	10,455,448	369,019.00	28.33	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-3 Part IV Date/Time Prepared: 10/30/2019 3:37 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	576,894	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,040,892	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	14,886	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	20,602	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	447	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	6,467	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	367,065	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,641,761	17.00
18.00	Medicare Taxes - Employers Portion Only	383,960	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	72,385	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,125,359	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-3 Part V Date/Time Prepared: 10/30/2019 3:37 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	842,173	6,125,359	1.00
2.00	Hospital	842,173	6,125,359	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-7 | Date/Time Prepared: 10/30/2019 3:37 pm

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	3	0	3	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	14	0	14	5.00
6.00		RVL	14	0	14	6.00
7.00		RHX	16	0	16	7.00
8.00		RHL	9	0	9	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	57	0	57	12.00
13.00		RUB	143	0	143	13.00
14.00		RUA	91	0	91	14.00
15.00		RVC	116	0	116	15.00
16.00		RVB	301	0	301	16.00
17.00		RVA	276	0	276	17.00
18.00		RHC	24	0	24	18.00
19.00		RHB	113	0	113	19.00
20.00		RHA	170	0	170	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	58	0	58	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	6	0	6	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	10	0	10	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	8	0	8	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	23	0	23	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	62	0	62	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	101	0	101	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-7 | Date/Time Prepared: 10/30/2019 3:37 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	16	0	16	78.00
199.00		AAA	64	0	64	199.00
200.00	TOTAL		1,695	0	1,695	200.00

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

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	3,878,425			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet S-10 | Date/Time Prepared: 10/30/2019 3:37 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.187854	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	18,411,787	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,501,923	5.00
6.00	Medicaid charges	118,989,238	6.00
7.00	Medicaid cost (line 1 times line 6)	22,352,604	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,438,894	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)	86,416	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	1,737,479	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	326,392	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	239,976	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,678,870	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)	12,083,588	0	12,083,588	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,269,950	0	2,269,950	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)	2,269,950	0	2,269,950	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)	12,273,585	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	275,749	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	424,230	27.01
28.00	Non-Medicare bad debt expense (see instructions)	11,849,355	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,374,430	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,644,380	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,323,250	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet A | Date/Time Prepared: 10/30/2019 3:37 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,027,679	2,027,679	1,071,843	3,099,522	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,284,181	3,284,181	750,759	4,034,940	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	284,206	107,640	391,846	4,090,166	4,482,012	4.00
5.01	00590	REVENUE CYCLE	1,775,452	4,083,791	5,859,243	-231,715	5,627,528	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	56,393	165,034	221,427	0	221,427	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	1,671,162	20,576,791	22,247,953	-5,371,542	16,876,411	5.03
7.00	00700	OPERATION OF PLANT	1,064,243	2,743,235	3,807,478	938,297	4,745,775	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,114	323,215	324,329	0	324,329	8.00
9.00	00900	HOUSEKEEPING	628,059	278,894	906,953	1,828	908,781	9.00
10.00	01000	DIETARY	0	1,937,842	1,937,842	-949,592	988,250	10.00
11.00	01100	CAFETERIA	0	0	0	948,382	948,382	11.00
13.00	01300	NURSING ADMINISTRATION	1,662,335	332,529	1,994,864	203,676	2,198,540	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	222,127	4,156,011	4,378,138	-3,762,856	615,282	14.00
15.00	01500	PHARMACY	1,437,960	3,109,883	4,547,843	-2,977,123	1,570,720	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	138,109	398,667	536,776	0	536,776	16.00
17.00	01700	SOCIAL SERVICE	789,392	69,123	858,515	0	858,515	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	468,734	468,734	0	468,734	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,383,725	3,347,901	9,731,626	-3,064,854	6,666,772	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	3,061,443	3,061,443	33.00
40.00	04000	SUBPROVIDER - IPF	1,542,117	685,598	2,227,715	0	2,227,715	40.00
44.00	04400	SKILLED NURSING FACILITY	1,071,481	163,558	1,235,039	-9	1,235,030	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	708,457	1,336,790	2,045,247	185,846	2,231,093	50.00
51.00	05100	RECOVERY ROOM	246,216	17,496	263,712	0	263,712	51.00
53.00	05300	ANESTHESIOLOGY	0	1,284,254	1,284,254	0	1,284,254	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,051,553	840,181	1,891,734	419,130	2,310,864	54.00
54.01	03630	ULTRA SOUND	322,750	70,808	393,558	-393,558	0	54.01
56.00	05600	RADIOISOTOPE	90,780	132,376	223,156	-223,156	0	56.00
57.00	05700	CT SCAN	208,592	146,096	354,688	-354,688	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,750,685	1,750,685	59.00
60.00	06000	LABORATORY	1,841,228	1,303,674	3,144,902	-310,086	2,834,816	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	156,911	156,911	62.00
65.00	06500	RESPIRATORY THERAPY	591,898	129,008	720,906	-7,835	713,071	65.00
66.00	06600	PHYSICAL THERAPY	396,030	35,425	431,455	-106	431,349	66.00
67.00	06700	OCCUPATIONAL THERAPY	303,978	24,450	328,428	0	328,428	67.00
68.00	06800	SPEECH PATHOLOGY	37,834	4,606	42,440	0	42,440	68.00
69.00	06900	ELECTROCARDIOLOGY	992,142	1,207,297	2,199,439	-2,101,079	98,360	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	636,114	636,114	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,837,664	2,837,664	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,700,722	2,700,722	73.00
74.00	07400	RENAL DIALYSIS	0	262,854	262,854	0	262,854	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	393,279	-62,959	330,320	-159	330,161	76.02
76.03	03952	WOUND CARE	657,094	309,635	966,729	-1,660	965,069	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	18,275	1,542	19,817	0	19,817	90.00
91.00	09100	EMERGENCY	1,872,691	1,383,333	3,256,024	-698	3,255,326	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,460,672	56,687,172	85,147,844	2,750	85,150,594	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	57	57	0	57	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,750	2,750	-2,750	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	28,460,672	56,689,979	85,150,651	0	85,150,651	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet A | Date/Time Prepared: 10/30/2019 3:37 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,766,495	4,866,017		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-216,523	3,818,417		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,662	4,478,350		4.00
5.01	00590	REVENUE CYCLE	-90,528	5,537,000		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	221,427		5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	-2,617,537	14,258,874		5.03
7.00	00700	OPERATION OF PLANT	-35,801	4,709,974		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-6,347	317,982		8.00
9.00	00900	HOUSEKEEPING	0	908,781		9.00
10.00	01000	DIETARY	0	988,250		10.00
11.00	01100	CAFETERIA	-2,931	945,451		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,198,540		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	615,282		14.00
15.00	01500	PHARMACY	0	1,570,720		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5	536,771		16.00
17.00	01700	SOCIAL SERVICE	0	858,515		17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	468,734		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,332,307	5,334,465		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	3,061,443		33.00
40.00	04000	SUBPROVIDER - IPF	-509,220	1,718,495		40.00
44.00	04400	SKILLED NURSING FACILITY	0	1,235,030		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-807,864	1,423,229		50.00
51.00	05100	RECOVERY ROOM	0	263,712		51.00
53.00	05300	ANESTHESIOLOGY	0	1,284,254		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,139	2,309,725		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,750,685		59.00
60.00	06000	LABORATORY	-800	2,834,016		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	156,911		62.00
65.00	06500	RESPIRATORY THERAPY	0	713,071		65.00
66.00	06600	PHYSICAL THERAPY	0	431,349		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	328,428		67.00
68.00	06800	SPEECH PATHOLOGY	0	42,440		68.00
69.00	06900	ELECTROCARDIOLOGY	-35,454	62,906		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	636,114		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,837,664		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,700,722		73.00
74.00	07400	RENAL DIALYSIS	0	262,854		74.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	330,161		76.02
76.03	03952	WOUND CARE	-5,000	960,069		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	19,817		90.00
91.00	09100	EMERGENCY	-400,938	2,854,388		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,299,561	80,851,033		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	57		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	MEALS ON WHEELS	0	0		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,299,561	80,851,090		200.00

RECLASSIFICATIONS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet A-6 | Date/Time Prepared: 10/30/2019 3:37 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,090,572	1.00
2.00		0.00	0	0	2.00
	0		0	4,090,572	
	C - LEASE AND RENTAL				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	741,093	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	28,502	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
	0		0	769,595	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	148,571	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	894,770	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,666	3.00
	0		0	1,053,007	
	E - REPAIRS & MAINTENANCE				
1.00	OPERATION OF PLANT	7.00	0	926,804	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
	TOTALS		0	926,804	
	F - CNO				
1.00	NURSING ADMINISTRATION	13.00	210,113	0	1.00
	0		210,113	0	
	G - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	636,114	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,837,664	2.00
3.00	OPERATING ROOM	50.00	0	214,006	3.00
	0		0	3,687,784	
	H - DRUGS AND IV COSTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,700,722	1.00
	0		0	2,700,722	
	J - RADIOLOGY				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	622,122	157,636	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		622,122	157,636	
	K - DIETARY				
1.00	CAFETERIA	11.00	0	948,382	1.00
	0		0	948,382	
	L - MISC DEPARTMENTS				
1.00	BURN INTENSIVE CARE UNIT	33.00	1,905,934	1,155,509	1.00
2.00	CARDIAC CATHETERIZATION	59.00	904,390	846,295	2.00
3.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	156,911	3.00
	0		2,810,324	2,158,715	

RECLASSIFICATIONS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet A-6 | Date/Time Prepared: 10/30/2019 3:37 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	M - UTILITIES RECLASS				
1.00	OPERATION OF PLANT	7.00	0	11,923	1.00
2.00	HOUSEKEEPING	9.00	0	2,815	2.00
3.00		0.00	0	0	3.00
	0		0	14,738	
500.00	Grand Total: Increases		3,642,559	16,507,955	500.00

RECLASSIFICATIONS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet A-6 | Date/Time Prepared: 10/30/2019 3:37 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	4,090,463	0	1.00
2.00	REVENUE CYCLE	5.01	0	109	0	2.00
	0		0	4,090,572		
	C - LEASE AND RENTAL					
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	13,687	10	1.00
2.00	OPERATION OF PLANT	7.00	0	430	10	2.00
3.00	DIETARY	10.00	0	1,210	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	1,122	0	4.00
5.00	PHARMACY	15.00	0	276,401	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	1,119	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	165,422	0	7.00
8.00	LABORATORY	60.00	0	109,112	0	8.00
9.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02	0	159	0	9.00
10.00	WOUND CARE	76.03	0	333	0	10.00
11.00	REVENUE CYCLE	5.01	0	3,430	0	11.00
12.00	CENTRAL SERVICES & SUPPLY	14.00	0	195,778	0	12.00
13.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	307	0	13.00
14.00	OPERATING ROOM	50.00	0	1,085	0	14.00
	0		0	769,595		
	D - OTHER CAPITAL COSTS					
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	1,053,007	12	1.00
2.00		0.00	0	0	13	2.00
3.00		0.00	0	0	12	3.00
	0		0	1,053,007		
	E - REPAIRS & MAINTENANCE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	99	0	1.00
2.00	REVENUE CYCLE	5.01	0	221,356	0	2.00
3.00	ADMINISTRATIVE AND GENERAL	5.03	0	2,082	0	3.00
4.00	HOUSEKEEPING	9.00	0	987	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	5,315	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	118,563	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	2,292	0	7.00
8.00	SKILLED NURSING FACILITY	44.00	0	9	0	8.00
9.00	OPERATING ROOM	50.00	0	27,075	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	189,478	0	10.00
11.00	ULTRA SOUND	54.01	0	35,772	0	11.00
12.00	RADIOISOTOPE	56.00	0	29,872	0	12.00
13.00	CT SCAN	57.00	0	126,000	0	13.00
14.00	LABORATORY	60.00	0	44,063	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	7,673	0	15.00
16.00	PHYSICAL THERAPY	66.00	0	106	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	0	111,287	0	17.00
18.00	WOUND CARE	76.03	0	1,327	0	18.00
19.00	EMERGENCY	91.00	0	698	0	19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,750	0	20.00
	TOTALS		0	926,804		
	F - CNO					
1.00	ADMINISTRATIVE AND GENERAL	5.03	210,113	0	0	1.00
	0		210,113	0		
	G - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,448,515	0	1.00
2.00	RESPIRATORY THERAPY	65.00	0	162	0	2.00
3.00	ELECTROCARDIOLOGY	69.00	0	239,107	0	3.00
	0		0	3,687,784		
	H - DRUGS AND IV COSTS					
1.00	PHARMACY	15.00	0	2,700,722	0	1.00
	0		0	2,700,722		
	J - RADIOLOGY					
1.00	ULTRA SOUND	54.01	322,750	35,036	0	1.00
2.00	RADIOISOTOPE	56.00	90,780	102,504	0	2.00
3.00	CT SCAN	57.00	208,592	20,096	0	3.00
	0		622,122	157,636		
	K - DIETARY					
1.00	DIETARY	10.00	0	948,382	0	1.00
	0		0	948,382		
	L - MISC DEPARTMENTS					
1.00	ADULTS & PEDIATRICS	30.00	1,905,934	1,155,509	0	1.00
2.00	LABORATORY	60.00	0	156,911	0	2.00
3.00	ELECTROCARDIOLOGY	69.00	904,390	846,295	0	3.00
	0		2,810,324	2,158,715		

RECLASSIFICATIONS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet A-6 | Date/Time Prepared: 10/30/2019 3:37 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	M - UTILITIES RECLASS						
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	2,190	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,728	0		2.00
3.00	REVENUE CYCLE	5.01	0	6,820	0		3.00
	0		0	14,738			
500.00	Grand Total: Decreases		3,642,559	16,507,955			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 10/30/2019 3:37 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	9,348,028	0	0	0	0	1.00
2.00	Land Improvements	1,775,835	0	0	0	0	2.00
3.00	Buildings and Fixtures	28,546,021	13,628	0	13,628	0	3.00
4.00	Building Improvements	30,465,532	1,031,831	0	1,031,831	0	4.00
5.00	Fixed Equipment	18,710,278	27,364	0	27,364	7,884	5.00
6.00	Movable Equipment	54,148,241	664,337	0	664,337	1,125,583	6.00
7.00	HIT designated Assets	2,833,813	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	145,827,748	1,737,160	0	1,737,160	1,133,467	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	145,827,748	1,737,160	0	1,737,160	1,133,467	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	9,348,028	0	1.00
2.00	Land Improvements	1,775,835	0	2.00
3.00	Buildings and Fixtures	28,559,649	0	3.00
4.00	Building Improvements	31,497,363	0	4.00
5.00	Fixed Equipment	18,729,758	0	5.00
6.00	Movable Equipment	53,686,995	0	6.00
7.00	HIT designated Assets	2,833,813	0	7.00
8.00	Subtotal (sum of lines 1-7)	146,431,441	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	146,431,441	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 10/30/2019 3:37 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,027,679	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,284,181	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,311,860	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2,027,679	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,284,181	2.00
3.00	Total (sum of lines 1-2)	0	5,311,860	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet A-7 Part III Date/Time Prepared: 10/30/2019 3:37 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	71,178,347	0	71,178,347	0.486538	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	75,117,296	0	75,117,296	0.513462	0	2.00
3.00	Total (sum of lines 1-2)	146,295,643	0	146,295,643	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,635,215	26,252	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,922,653	886,098	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,557,868	912,350	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,161,209	148,571	894,770	0	4,866,017	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,666	0	0	3,818,417	2.00
3.00	Total (sum of lines 1-2)	1,161,209	158,237	894,770	0	8,684,434	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet A-8 | Date/Time Prepared: 10/30/2019 3:37 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-2,250	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-8,081	ADMINISTRATIVE AND GENERAL	5.03	0	7.00
8.00	Television and radio service (chapter 21)	A	-35,801	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,841,475			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	424,062			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-2,931	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-640	ADMINISTRATIVE AND GENERAL	5.03	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	549,590	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-639,678	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PARKING GARAGE & MISC INCOME	B	-63,946	ADMINISTRATIVE AND GENERAL	5.03	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet A-8 | Date/Time Prepared: 10/30/2019 3:37 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MARKETING EXPENSE	A	-393,199	ADMINISTRATIVE AND GENERAL	5.03	0	33.01
33.02	PENALTIES	A	-17	ADMINISTRATIVE AND GENERAL	5.03	0	33.02
33.04	SENIOR CIRCLE	A	-197	ADMINISTRATIVE AND GENERAL	5.03	0	33.04
33.06	PATIENT PHONE WAGE COSTS	A	-17,014	ADMINISTRATIVE AND GENERAL	5.03	0	33.06
33.07	PATIENT PHONES BENEFITS	A	-3,662	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	PATIENT PHONE DEPRECIATION COST	A	-232	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	PATIENT TV DEPRECIATION	A	-5,211	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.11	PHYSICIAN RECRUITING	A	-91,454	ADMINISTRATIVE AND GENERAL	5.03	0	33.11
33.12	LOBBYING EXPENSE IN DUES	A	-2,683	ADMINISTRATIVE AND GENERAL	5.03	0	33.12
33.13	CHARITABLE CONTRIBUTIONS	A	-83,895	ADMINISTRATIVE AND GENERAL	5.03	0	33.13
33.15	IMPUTED RENT	A	-18,720	CAP REL COSTS-MVBLE EQUIP	2.00	10	33.15
33.16	NONALLOWABLE LEGAL EXPENSES	A	-62,122	ADMINISTRATIVE AND GENERAL	5.03	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,299,561				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 10/30/2019 3:37 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL-RELATED INTEREST	1,161,209	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	13,424	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	2,334	0	3.00
4.00	5.01	REVENUE CYCLE	PASI OPERATING COSTS	211,350	301,878	4.00
4.04	5.03	ADMINISTRATIVE AND GENERAL	Shared Service Center Alloca	1,119,113	861,971	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	44,522	0	4.05
4.06	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm	281,259	0	4.06
4.07	5.03	ADMINISTRATIVE AND GENERAL	Non-Capital Home Office Cost	2,849,002	0	4.07
4.08	5.03	ADMINISTRATIVE AND GENERAL	Malpractice Costs	235,002	942,777	4.08
4.09	2.00	CAP REL COSTS-MVBLE EQUIP	CIG Leased Equipment	470,490	306,765	4.09
4.10	5.03	ADMINISTRATIVE AND GENERAL	Management Fees	0	2,354,238	4.10
4.11	5.03	ADMINISTRATIVE AND GENERAL	401K Fees	0	4,402	4.11
4.12	5.03	ADMINISTRATIVE AND GENERAL	Audit Fees	0	41,425	4.12
4.13	5.03	ADMINISTRATIVE AND GENERAL	Corporate Overhead Allocatio	0	818,548	4.13
4.14	5.03	ADMINISTRATIVE AND GENERAL	HIIM Allocation	0	283,681	4.14
4.15	5.03	ADMINISTRATIVE AND GENERAL	PASI Lien Unit Collection Fe	0	24,473	4.15
4.16	5.03	ADMINISTRATIVE AND GENERAL	PPSI Fees	0	17,138	4.16
4.17	8.00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICES	342,806	349,153	4.17
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,730,511	6,306,449	5.00

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

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

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

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

6.00	B		0.00	CHS, INC	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00	C		33.00	SHARED LAUNDRY	33.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 10/30/2019 3:37 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,161,209	11		1.00
2.00	13,424	9		2.00
3.00	2,334	9		3.00
4.00	-90,528	0		4.00
4.04	257,142	0		4.04
4.05	44,522	9		4.05
4.06	281,259	9		4.06
4.07	2,849,002	0		4.07
4.08	-707,775	0		4.08
4.09	163,725	10		4.09
4.10	-2,354,238	0		4.10
4.11	-4,402	0		4.11
4.12	-41,425	0		4.12
4.13	-818,548	0		4.13
4.14	-283,681	0		4.14
4.15	-24,473	0		4.15
4.16	-17,138	0		4.16
4.17	-6,347	0		4.17
5.00	424,062			5.00

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

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

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

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

6.00	OWNER		6.00
7.00	DEBT COLLECTION		7.00
8.00	LAUNDRY		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 10/30/2019 3:37 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,332,307	1,332,307	0	0	0	1.00
2.00	50.00	OPERATING ROOM	807,864	807,864	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	1,139	1,139	0	0	0	3.00
4.00	60.00	LABORATORY	800	800	0	0	0	4.00
5.00	91.00	EMERGENCY	400,938	400,938	0	0	0	5.00
6.00	5.03	ADMINISTRATIVE AND GENERAL	748,753	748,753	0	0	0	6.00
7.00	76.03	WOUND CARE	5,000	5,000	0	0	0	7.00
8.00	40.00	SUBPROVIDER - IPF	509,220	509,220	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	35,454	35,454	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,841,475	3,841,475	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	5.03	ADMINISTRATIVE AND GENERAL	0	0	0	0	0	6.00
7.00	76.03	WOUND CARE	0	0	0	0	0	7.00
8.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,332,307		1.00
2.00	50.00	OPERATING ROOM	0	0	0	807,864		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,139		3.00
4.00	60.00	LABORATORY	0	0	0	800		4.00
5.00	91.00	EMERGENCY	0	0	0	400,938		5.00
6.00	5.03	ADMINISTRATIVE AND GENERAL	0	0	0	748,753		6.00
7.00	76.03	WOUND CARE	0	0	0	5,000		7.00
8.00	40.00	SUBPROVIDER - IPF	0	0	0	509,220		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	35,454		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,841,475		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet B Part I Date/Time Prepared: 10/30/2019 3:37 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	REVENUE CYCLE	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,866,017	4,866,017				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,818,417		3,818,417			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,478,350	55,076	43,219	4,576,645		4.00
5.01	00590	REVENUE CYCLE	5,537,000	195,362	153,303	288,383	6,174,048	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	221,427	135,688	106,476	9,160	0	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	14,258,874	105,565	82,838	237,315	0	5.03
7.00	00700	OPERATION OF PLANT	4,709,974	1,323,949	1,038,916	172,863	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	317,982	43,241	33,932	181	0	8.00
9.00	00900	HOUSEKEEPING	908,781	654,678	513,733	102,014	0	9.00
10.00	01000	DIETARY	988,250	204,513	160,483	0	0	10.00
11.00	01100	CAFETERIA	945,451	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,198,540	74,928	58,797	304,138	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	615,282	0	0	36,080	0	14.00
15.00	01500	PHARMACY	1,570,720	0	0	233,565	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	536,771	122,546	96,164	22,433	0	16.00
17.00	01700	SOCIAL SERVICE	858,515	0	0	128,219	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	468,734	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,334,465	435,460	341,710	727,318	382,220	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	3,061,443	81,849	64,228	309,577	210,199	33.00
40.00	04000	SUBPROVIDER - IPF	1,718,495	62,195	48,805	250,483	451,458	40.00
44.00	04400	SKILLED NURSING FACILITY	1,235,030	114,458	89,817	174,039	56,559	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,423,229	200,521	157,351	115,073	443,413	50.00
51.00	05100	RECOVERY ROOM	263,712	75,220	59,026	39,992	45,650	51.00
53.00	05300	ANESTHESIOLOGY	1,284,254	0	0	0	48,158	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,309,725	192,363	150,949	271,852	906,862	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	1,750,685	21,428	16,815	146,898	266,326	59.00
60.00	06000	LABORATORY	2,834,016	164,644	129,198	299,067	762,539	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	156,911	9,022	7,079	0	20,414	62.00
65.00	06500	RESPIRATORY THERAPY	713,071	66,899	52,496	96,141	167,259	65.00
66.00	06600	PHYSICAL THERAPY	431,349	86,926	68,212	64,326	51,544	66.00
67.00	06700	OCCUPATIONAL THERAPY	328,428	33,274	26,111	49,375	52,759	67.00
68.00	06800	SPEECH PATHOLOGY	42,440	12,815	10,056	6,145	2,931	68.00
69.00	06900	ELECTROCARDIOLOGY	62,906	12,196	9,571	14,253	45,577	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	636,114	0	0	0	422,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,837,664	0	0	0	263,379	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,700,722	28,828	22,621	0	867,827	73.00
74.00	07400	RENAL DIALYSIS	262,854	23,459	18,408	0	18,709	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	330,161	38,024	29,838	63,880	6,529	76.02
76.03	03952	WOUND CARE	960,069	100,243	78,662	106,730	57,653	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	19,817	24,813	19,471	2,968	1,941	90.00
91.00	09100	EMERGENCY	2,854,388	154,023	120,864	304,177	621,959	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	80,851,033	4,854,206	3,809,149	4,576,645	6,174,048	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	57	11,811	9,268	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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)	80,851,090	4,866,017	3,818,417	4,576,645	6,174,048	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet B Part I | Date/Time Prepared: 10/30/2019 3:37 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	Subtotal	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	472,751					5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	1,274	14,685,866	14,685,866			5.03
7.00	00700	OPERATION OF PLANT	442	7,246,144	1,608,363	8,854,507		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	395,336	87,748	125,519	608,603	8.00
9.00	00900	HOUSEKEEPING	16,140	2,195,346	487,272	1,900,369	0	9.00
10.00	01000	DIETARY	0	1,353,246	300,362	593,650	0	10.00
11.00	01100	CAFETERIA	0	945,451	209,849	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	710	2,637,113	585,326	217,499	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,268	663,630	147,297	0	0	14.00
15.00	01500	PHARMACY	1,851	1,806,136	400,885	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	165	778,079	172,700	355,722	0	16.00
17.00	01700	SOCIAL SERVICE	113	986,847	219,038	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	468,734	104,039	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,741	7,240,914	1,607,172	1,264,034	155,196	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	13,898	3,741,194	830,384	237,589	54,899	33.00
40.00	04000	SUBPROVIDER - IPF	3,039	2,534,475	562,544	180,538	55,285	40.00
44.00	04400	SKILLED NURSING FACILITY	4,077	1,673,980	371,552	332,245	49,983	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,058	2,378,645	527,957	582,064	43,213	50.00
51.00	05100	RECOVERY ROOM	41	483,641	107,348	218,346	13,898	51.00
53.00	05300	ANESTHESIOLOGY	7	1,332,419	295,740	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,340	3,840,091	852,335	558,383	38,893	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	25,973	2,228,125	494,548	62,201	23,335	59.00
60.00	06000	LABORATORY	34,609	4,224,073	937,563	477,922	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	10,549	203,975	45,274	26,188	0	62.00
65.00	06500	RESPIRATORY THERAPY	5,276	1,101,142	244,406	194,191	0	65.00
66.00	06600	PHYSICAL THERAPY	277	702,634	155,955	252,326	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	54	490,001	108,759	96,587	0	67.00
68.00	06800	SPEECH PATHOLOGY	10	74,397	16,513	37,198	0	68.00
69.00	06900	ELECTROCARDIOLOGY	250	144,753	32,129	35,403	2,576	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,179	1,098,476	243,814	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	193,855	3,294,898	731,326	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,619,998	803,484	83,679	0	73.00
74.00	07400	RENAL DIALYSIS	310	323,740	71,856	68,095	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	550	468,982	104,094	110,376	0	76.02
76.03	03952	WOUND CARE	14,364	1,317,721	292,477	290,981	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10	69,020	15,319	72,025	25,084	90.00
91.00	09100	EMERGENCY	25,317	4,080,728	905,746	447,092	146,241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	472,747	80,829,950	14,681,174	8,820,222	608,603	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4	21,140	4,692	34,285	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	472,751	80,851,090	14,685,866	8,854,507	608,603	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet B Part I | Date/Time Prepared: 10/30/2019 3:37 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	4,582,987					9.00
10.00	01000	DIETARY	398,425	2,645,683				10.00
11.00	01100	CAFETERIA	0	0	1,155,300			11.00
13.00	01300	NURSING ADMINISTRATION	145,973	0	72,034	3,657,945		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	16,174	0	827,101	14.00
15.00	01500	PHARMACY	0	0	49,982	47,640	3,464	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	238,741	0	11,349	0	309	16.00
17.00	01700	SOCIAL SERVICE	0	0	35,915	183,009	211	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	848,350	1,056,276	250,557	1,191,140	36,948	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	159,456	187,803	86,305	553,575	26,013	33.00
40.00	04000	SUBPROVIDER - IPF	121,167	396,078	91,232	343,255	5,687	40.00
44.00	04400	SKILLED NURSING FACILITY	222,984	340,847	49,201	305,309	7,630	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	390,649	0	33,673	128,681	73,102	50.00
51.00	05100	RECOVERY ROOM	146,542	0	9,276	70,754	77	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	14	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	374,755	0	87,392	0	15,609	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	41,746	0	35,745	155,994	48,612	59.00
60.00	06000	LABORATORY	320,754	0	106,828	0	64,776	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	17,576	0	0	0	19,744	62.00
65.00	06500	RESPIRATORY THERAPY	130,330	0	29,867	0	9,876	65.00
66.00	06600	PHYSICAL THERAPY	169,347	0	17,771	0	518	66.00
67.00	06700	OCCUPATIONAL THERAPY	64,824	0	11,791	0	102	67.00
68.00	06800	SPEECH PATHOLOGY	24,965	0	1,495	0	19	68.00
69.00	06900	ELECTROCARDIOLOGY	23,760	0	3,975	0	469	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	75,201	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	362,819	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,161	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	45,702	0	0	0	580	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	74,078	0	26,265	0	1,029	76.02
76.03	03952	WOUND CARE	195,290	0	31,124	152,577	26,884	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	48,339	0	748	5,373	18	90.00
91.00	09100	EMERGENCY	300,063	0	96,601	520,638	47,383	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,559,977	1,981,004	1,155,300	3,657,945	827,094	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,010	0	0	0	7	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	403,903	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	260,776	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,582,987	2,645,683	1,155,300	3,657,945	827,101	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet B Part I | Date/Time Prepared: 10/30/2019 3:37 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	17.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,308,107					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,556,900				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,425,020			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	572,773		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	96,374	761,177	572,773	15,080,911	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	53,000	134,614	0	6,064,832	33.00
40.00	04000	SUBPROVIDER - IPF	0	113,832	282,668	0	4,686,761	40.00
44.00	04400	SKILLED NURSING FACILITY	0	14,261	246,561	0	3,614,553	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	111,803	0	0	4,269,787	50.00
51.00	05100	RECOVERY ROOM	0	11,510	0	0	1,061,392	51.00
53.00	05300	ANESTHESIOLOGY	0	12,143	0	0	1,640,316	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	228,819	0	0	5,996,277	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	67,152	0	0	3,157,458	59.00
60.00	06000	LABORATORY	0	192,269	0	0	6,324,185	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	5,147	0	0	317,904	62.00
65.00	06500	RESPIRATORY THERAPY	0	42,173	0	0	1,751,985	65.00
66.00	06600	PHYSICAL THERAPY	0	12,996	0	0	1,311,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13,303	0	0	785,367	67.00
68.00	06800	SPEECH PATHOLOGY	0	739	0	0	155,326	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,492	0	0	254,557	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	106,451	0	0	1,523,942	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	66,409	0	0	4,455,452	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,308,107	218,816	0	0	7,090,245	73.00
74.00	07400	RENAL DIALYSIS	0	4,717	0	0	514,690	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,646	0	0	786,470	76.02
76.03	03952	WOUND CARE	0	14,537	0	0	2,321,591	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	489	0	0	236,415	90.00
91.00	09100	EMERGENCY	0	156,822	0	0	6,701,314	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,308,107	1,556,900	1,425,020	572,773	80,103,277	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	83,134	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	403,903	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	260,776	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,308,107	1,556,900	1,425,020	572,773	80,851,090	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet B Part I | Date/Time Prepared: 10/30/2019 3:37 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	REVENUE CYCLE				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00591	ADMINISTRATIVE AND GENERAL				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-572,773	14,508,138		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	6,064,832		33.00
40.00	04000	SUBPROVIDER - IPF	0	4,686,761		40.00
44.00	04400	SKILLED NURSING FACILITY	0	3,614,553		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,269,787		50.00
51.00	05100	RECOVERY ROOM	0	1,061,392		51.00
53.00	05300	ANESTHESIOLOGY	0	1,640,316		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,996,277		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,157,458		59.00
60.00	06000	LABORATORY	0	6,324,185		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	317,904		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,751,985		65.00
66.00	06600	PHYSICAL THERAPY	0	1,311,547		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	785,367		67.00
68.00	06800	SPEECH PATHOLOGY	0	155,326		68.00
69.00	06900	ELECTROCARDIOLOGY	0	254,557		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,523,942		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,455,452		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,090,245		73.00
74.00	07400	RENAL DIALYSIS	0	514,690		74.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	786,470		76.02
76.03	03952	WOUND CARE	0	2,321,591		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	236,415		90.00
91.00	09100	EMERGENCY	0	6,701,314		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-572,773	79,530,504		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	83,134		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	403,903		192.00
194.00	07950	MEALS ON WHEELS	0	260,776		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	-572,773	80,278,317		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet B Part II Date/Time Prepared: 10/30/2019 3:37 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	55,076	43,219	98,295	98,295	4.00
5.01	00590	REVENUE CYCLE	0	195,362	153,303	348,665	6,195	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	135,688	106,476	242,164	197	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	0	105,565	82,838	188,403	5,098	5.03
7.00	00700	OPERATION OF PLANT	0	1,323,949	1,038,916	2,362,865	3,713	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	43,241	33,932	77,173	4	8.00
9.00	00900	HOUSEKEEPING	0	654,678	513,733	1,168,411	2,191	9.00
10.00	01000	DIETARY	0	204,513	160,483	364,996	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	74,928	58,797	133,725	6,533	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	775	14.00
15.00	01500	PHARMACY	0	0	0	0	5,017	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	122,546	96,164	218,710	482	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	2,754	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	435,460	341,710	777,170	15,610	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	81,849	64,228	146,077	6,650	33.00
40.00	04000	SUBPROVIDER - IPF	0	62,195	48,805	111,000	5,380	40.00
44.00	04400	SKILLED NURSING FACILITY	0	114,458	89,817	204,275	3,738	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	200,521	157,351	357,872	2,472	50.00
51.00	05100	RECOVERY ROOM	0	75,220	59,026	134,246	859	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	192,363	150,949	343,312	5,839	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,428	16,815	38,243	3,155	59.00
60.00	06000	LABORATORY	0	164,644	129,198	293,842	6,424	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	9,022	7,079	16,101	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	66,899	52,496	119,395	2,065	65.00
66.00	06600	PHYSICAL THERAPY	0	86,926	68,212	155,138	1,382	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	33,274	26,111	59,385	1,061	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,815	10,056	22,871	132	68.00
69.00	06900	ELECTROCARDIOLOGY	0	12,196	9,571	21,767	306	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,828	22,621	51,449	0	73.00
74.00	07400	RENAL DIALYSIS	0	23,459	18,408	41,867	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	38,024	29,838	67,862	1,372	76.02
76.03	03952	WOUND CARE	0	100,243	78,662	178,905	2,293	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	24,813	19,471	44,284	64	90.00
91.00	09100	EMERGENCY	0	154,023	120,864	274,887	6,534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,854,206	3,809,149	8,663,355	98,295	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,811	9,268	21,079	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,866,017	3,818,417	8,684,434	98,295	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet B Part II Date/Time Prepared: 10/30/2019 3:37 pm

		Cost Center Description	REVENUE CYCLE	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE	354,860					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	242,361				5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	0	653	194,154			5.03
7.00	00700	OPERATION OF PLANT	0	227	21,287	2,388,092		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,160	33,853	112,190	8.00
9.00	00900	HOUSEKEEPING	0	8,274	6,441	512,533	0	9.00
10.00	01000	DIETARY	0	0	3,970	160,109	0	10.00
11.00	01100	CAFETERIA	0	0	2,774	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	364	7,737	58,660	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,290	1,947	0	0	14.00
15.00	01500	PHARMACY	0	949	5,299	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	85	2,283	95,940	0	16.00
17.00	01700	SOCIAL SERVICE	0	58	2,895	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	1,375	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,964	10,121	21,245	340,915	28,609	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	12,079	7,125	10,977	64,079	10,120	33.00
40.00	04000	SUBPROVIDER - IPF	25,943	1,558	7,436	48,692	10,191	40.00
44.00	04400	SKILLED NURSING FACILITY	3,250	2,090	4,911	89,608	9,214	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,480	20,024	6,979	156,985	7,966	50.00
51.00	05100	RECOVERY ROOM	2,623	21	1,419	58,889	2,562	51.00
53.00	05300	ANESTHESIOLOGY	2,767	4	3,909	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,187	4,276	11,267	150,598	7,170	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	15,304	13,315	6,537	16,776	4,301	59.00
60.00	06000	LABORATORY	43,819	17,743	12,393	128,897	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,173	5,408	598	7,063	0	62.00
65.00	06500	RESPIRATORY THERAPY	9,611	2,705	3,231	52,374	0	65.00
66.00	06600	PHYSICAL THERAPY	2,962	142	2,062	68,053	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,032	28	1,438	26,050	0	67.00
68.00	06800	SPEECH PATHOLOGY	168	5	218	10,033	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,619	128	425	9,548	475	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,260	20,599	3,223	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,135	99,378	9,667	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,869	0	10,621	22,569	0	73.00
74.00	07400	RENAL DIALYSIS	1,075	159	950	18,366	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	375	282	1,376	29,769	0	76.02
76.03	03952	WOUND CARE	3,313	7,364	3,866	78,479	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	112	5	203	19,425	4,624	90.00
91.00	09100	EMERGENCY	35,740	12,979	11,973	120,582	26,958	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	354,860	242,359	194,092	2,378,845	112,190	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2	62	9,247	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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)	354,860	242,361	194,154	2,388,092	112,190	202.00

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		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	1,697,850					9.00
10.00	01000	DIETARY	147,604	676,679				10.00
11.00	01100	CAFETERIA	0	0	2,774			11.00
13.00	01300	NURSING ADMINISTRATION	54,078	0	173	261,270		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	39	0	9,051	14.00
15.00	01500	PHARMACY	0	0	120	3,403	38	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	88,446	0	27	0	3	16.00
17.00	01700	SOCIAL SERVICE	0	0	86	13,072	2	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	314,287	270,160	600	85,075	404	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	59,073	48,034	207	39,540	285	33.00
40.00	04000	SUBPROVIDER - IPF	44,888	101,304	219	24,517	62	40.00
44.00	04400	SKILLED NURSING FACILITY	82,608	87,178	118	21,807	84	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	144,723	0	81	9,191	800	50.00
51.00	05100	RECOVERY ROOM	54,289	0	22	5,054	1	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	138,835	0	210	0	171	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	15,465	0	86	11,142	532	59.00
60.00	06000	LABORATORY	118,829	0	257	0	709	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,511	0	0	0	216	62.00
65.00	06500	RESPIRATORY THERAPY	48,283	0	72	0	108	65.00
66.00	06600	PHYSICAL THERAPY	62,738	0	43	0	6	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,015	0	28	0	1	67.00
68.00	06800	SPEECH PATHOLOGY	9,249	0	4	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,802	0	10	0	5	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	823	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,971	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,806	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	16,931	0	0	0	6	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	27,444	0	63	0	11	76.02
76.03	03952	WOUND CARE	72,349	0	75	10,898	294	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	17,908	0	2	384	0	90.00
91.00	09100	EMERGENCY	111,164	0	232	37,187	519	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,689,325	506,676	2,774	261,270	9,051	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,525	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	103,305	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	66,698	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,697,850	676,679	2,774	261,270	9,051	202.00

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		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	17.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	14,826					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	405,976				16.00
17.00	01700	SOCIAL SERVICE	0	0	18,867			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	1,375		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	25,135	10,079		1,921,374	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	13,823	1,782		419,851	33.00
40.00	04000	SUBPROVIDER - IPF	0	29,689	3,742		414,621	40.00
44.00	04400	SKILLED NURSING FACILITY	0	3,719	3,264		515,864	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	29,159	0		761,732	50.00
51.00	05100	RECOVERY ROOM	0	3,002	0		262,987	51.00
53.00	05300	ANESTHESIOLOGY	0	3,167	0		9,847	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	59,600	0		773,465	54.00
54.01	03630	ULTRA SOUND	0	0	0		0	54.01
56.00	05600	RADIOISOTOPE	0	0	0		0	56.00
57.00	05700	CT SCAN	0	0	0		0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	17,514	0		142,370	59.00
60.00	06000	LABORATORY	0	50,146	0		673,059	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,342	0		38,412	62.00
65.00	06500	RESPIRATORY THERAPY	0	10,999	0		248,843	65.00
66.00	06600	PHYSICAL THERAPY	0	3,390	0		295,916	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,469	0		118,507	67.00
68.00	06800	SPEECH PATHOLOGY	0	193	0		42,873	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,997	0		47,082	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	27,763	0		76,668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,320	0		145,471	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,826	57,070	0		227,210	73.00
74.00	07400	RENAL DIALYSIS	0	1,230	0		80,584	74.00
76.00	03950	MISC ANCILLARY	0	0	0		0	76.00
76.01	03951	SLEEP LAB	0	0	0		0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	429	0		128,983	76.02
76.03	03952	WOUND CARE	0	3,791	0		361,627	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	128	0		87,139	90.00
91.00	09100	EMERGENCY	0	40,901	0		679,656	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,826	405,976	18,867	0	8,474,141	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		38,915	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		103,305	192.00
194.00	07950	MEALS ON WHEELS	0	0	0		66,698	194.00
200.00		Cross Foot Adjustments				1,375	1,375	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,826	405,976	18,867	1,375	8,684,434	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet B Part II | Date/Time Prepared: 10/30/2019 3:37 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	REVENUE CYCLE				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00591	ADMINISTRATIVE AND GENERAL				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,921,374		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	419,851		33.00
40.00	04000	SUBPROVIDER - IPF	0	414,621		40.00
44.00	04400	SKILLED NURSING FACILITY	0	515,864		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	761,732		50.00
51.00	05100	RECOVERY ROOM	0	262,987		51.00
53.00	05300	ANESTHESIOLOGY	0	9,847		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	773,465		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	0	142,370		59.00
60.00	06000	LABORATORY	0	673,059		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	38,412		62.00
65.00	06500	RESPIRATORY THERAPY	0	248,843		65.00
66.00	06600	PHYSICAL THERAPY	0	295,916		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	118,507		67.00
68.00	06800	SPEECH PATHOLOGY	0	42,873		68.00
69.00	06900	ELECTROCARDIOLOGY	0	47,082		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	76,668		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	145,471		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	227,210		73.00
74.00	07400	RENAL DIALYSIS	0	80,584		74.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	128,983		76.02
76.03	03952	WOUND CARE	0	361,627		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	87,139		90.00
91.00	09100	EMERGENCY	0	679,656		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	8,474,141		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,915		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	103,305		192.00
194.00	07950	MEALS ON WHEELS	0	66,698		194.00
200.00		Cross Foot Adjustments	0	1,375		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	8,684,434		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet B-1 | Date/Time Prepared: 10/30/2019 3:37 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FOO TAGE)	MVBLE EQUIP (SQUARE FOO TAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	REVENUE CYCLE (GROSS CHAR GES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	416,929					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		416,929				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,719	4,719	28,176,466			4.00
5.01	00590	REVENUE CYCLE	16,739	16,739	1,775,452	423,362,560		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	11,626	11,626	56,393	0	7,017,107	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	9,045	9,045	1,461,049	0	18,913	5.03
7.00	00700	OPERATION OF PLANT	113,438	113,438	1,064,243	0	6,564	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,705	3,705	1,114	0	0	8.00
9.00	00900	HOUSEKEEPING	56,094	56,094	628,059	0	239,566	9.00
10.00	01000	DIETARY	17,523	17,523	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,420	6,420	1,872,448	0	10,546	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	222,127	0	182,103	14.00
15.00	01500	PHARMACY	0	0	1,437,960	0	27,472	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,500	10,500	138,109	0	2,451	16.00
17.00	01700	SOCIAL SERVICE	0	0	789,392	0	1,671	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,311	37,311	4,477,791	26,209,952	293,021	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	7,013	7,013	1,905,934	14,413,967	206,297	33.00
40.00	04000	SUBPROVIDER - IPF	5,329	5,329	1,542,117	30,957,832	45,104	40.00
44.00	04400	SKILLED NURSING FACILITY	9,807	9,807	1,071,481	3,878,425	60,514	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,181	17,181	708,457	30,406,145	579,740	50.00
51.00	05100	RECOVERY ROOM	6,445	6,445	246,216	3,130,379	610	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,302,370	108	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,482	16,482	1,673,675	62,175,916	123,788	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	1,836	1,836	904,390	18,262,740	385,520	59.00
60.00	06000	LABORATORY	14,107	14,107	1,841,228	52,289,561	513,714	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	773	773	0	1,399,853	156,584	62.00
65.00	06500	RESPIRATORY THERAPY	5,732	5,732	591,898	11,469,460	78,320	65.00
66.00	06600	PHYSICAL THERAPY	7,448	7,448	396,030	3,534,530	4,112	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,851	2,851	303,978	3,617,813	805	67.00
68.00	06800	SPEECH PATHOLOGY	1,098	1,098	37,834	200,967	148	68.00
69.00	06900	ELECTROCARDIOLOGY	1,045	1,045	87,752	3,125,356	3,716	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	28,950,381	596,391	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,060,682	2,877,386	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,470	2,470	0	59,509,499	0	73.00
74.00	07400	RENAL DIALYSIS	2,010	2,010	0	1,282,924	4,601	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,258	3,258	393,279	447,706	8,160	76.02
76.03	03952	WOUND CARE	8,589	8,589	657,094	3,953,416	213,205	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,126	2,126	18,275	133,124	142	90.00
91.00	09100	EMERGENCY	13,197	13,197	1,872,691	42,649,562	375,778	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	415,917	415,917	28,176,466	423,362,560	7,017,050	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,012	1,012	0	0	57	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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)	4,866,017	3,818,417	4,576,645	6,174,048	472,751	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.671093	9.158435	0.162428	0.014583	0.067371	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			98,295	354,860	242,361	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003489	0.000838	0.034539	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet B-1 | Date/Time Prepared: 10/30/2019 3:37 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FOOTAGE)	MVBLE EQUIP (SQUARE FOOTAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	REVENUE CYCLE (GROSS CHARGES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
		1.00	2.00	4.00	5.01	5.02	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet B-1 | Date/Time Prepared: 10/30/2019 3:37 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM.COST)	OPERATION OF PLANT (SQUARE FOOTAGE)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FOOTAGE)	
			5A.03	5.03	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	-14,685,866	66,165,224				5.03
7.00	00700	OPERATION OF PLANT	0	7,246,144	261,362			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	395,336	3,705	666,125		8.00
9.00	00900	HOUSEKEEPING	0	2,195,346	56,094	0	201,563	9.00
10.00	01000	DIETARY	0	1,353,246	17,523	0	17,523	10.00
11.00	01100	CAFETERIA	0	945,451	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,637,113	6,420	0	6,420	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	663,630	0	0	0	14.00
15.00	01500	PHARMACY	0	1,806,136	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	778,079	10,500	0	10,500	16.00
17.00	01700	SOCIAL SERVICE	0	986,847	0	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	468,734	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,240,914	37,311	169,865	37,311	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	3,741,194	7,013	60,088	7,013	33.00
40.00	04000	SUBPROVIDER - IPF	0	2,534,475	5,329	60,510	5,329	40.00
44.00	04400	SKILLED NURSING FACILITY	0	1,673,980	9,807	54,707	9,807	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,378,645	17,181	47,297	17,181	50.00
51.00	05100	RECOVERY ROOM	0	483,641	6,445	15,212	6,445	51.00
53.00	05300	ANESTHESIOLOGY	0	1,332,419	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,840,091	16,482	42,569	16,482	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,228,125	1,836	25,540	1,836	59.00
60.00	06000	LABORATORY	0	4,224,073	14,107	0	14,107	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	203,975	773	0	773	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,101,142	5,732	0	5,732	65.00
66.00	06600	PHYSICAL THERAPY	0	702,634	7,448	0	7,448	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	490,001	2,851	0	2,851	67.00
68.00	06800	SPEECH PATHOLOGY	0	74,397	1,098	0	1,098	68.00
69.00	06900	ELECTROCARDIOLOGY	0	144,753	1,045	2,819	1,045	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,098,476	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,294,898	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,619,998	2,470	0	2,470	73.00
74.00	07400	RENAL DIALYSIS	0	323,740	2,010	0	2,010	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	468,982	3,258	0	3,258	76.02
76.03	03952	WOUND CARE	0	1,317,721	8,589	0	8,589	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	69,020	2,126	27,455	2,126	90.00
91.00	09100	EMERGENCY	0	4,080,728	13,197	160,063	13,197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-14,685,866	66,144,084	260,350	666,125	200,551	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,140	1,012	0	1,012	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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)		14,685,866	8,854,507	608,603	4,582,987	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.221957	33.878326	0.913647	22.737243	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		194,154	2,388,092	112,190	1,697,850	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.002934	9.137105	0.168422	8.423421	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet B-1 | Date/Time Prepared: 10/30/2019 3:37 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (GROSS SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	116,307					10.00
11.00	01100	CAFETERIA	0	3,400,100				11.00
13.00	01300	NURSING ADMINISTRATION	0	212,000	10,677,225			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	47,600	0	6,559,415		14.00
15.00	01500	PHARMACY	0	147,100	139,058	27,472	2,688,280	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33,400	0	2,451	0	16.00
17.00	01700	SOCIAL SERVICE	0	105,700	534,187	1,671	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,435	737,400	3,476,831	293,021	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	8,256	254,000	1,615,840	206,297	0	33.00
40.00	04000	SUBPROVIDER - IPF	17,412	268,500	1,001,932	45,104	0	40.00
44.00	04400	SKILLED NURSING FACILITY	14,984	144,800	891,170	60,514	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	99,100	375,610	579,740	0	50.00
51.00	05100	RECOVERY ROOM	0	27,300	206,524	610	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	108	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	257,200	0	123,788	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	105,200	455,332	385,520	0	59.00
60.00	06000	LABORATORY	0	314,400	0	513,714	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	156,584	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	87,900	0	78,320	0	65.00
66.00	06600	PHYSICAL THERAPY	0	52,300	0	4,112	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	34,700	0	805	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,400	0	148	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,700	0	3,716	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	596,391	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,877,386	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,688,280	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,601	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	77,300	0	8,160	0	76.02
76.03	03952	WOUND CARE	0	91,600	445,358	213,205	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,200	15,684	142	0	90.00
91.00	09100	EMERGENCY	0	284,300	1,519,699	375,778	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,087	3,400,100	10,677,225	6,559,358	2,688,280	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	57	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,756	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	11,464	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,645,683	1,155,300	3,657,945	827,101	2,308,107	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.747410	0.339784	0.342593	0.126094	0.858581	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	676,679	2,774	261,270	9,051	14,826	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.818042	0.000816	0.024470	0.001380	0.005515	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet B-1 | Date/Time Prepared: 10/30/2019 3:37 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ROTATIONS)		
			16.00	17.00	22.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	REVENUE CYCLE					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00591	ADMINISTRATIVE AND GENERAL					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	423,362,560				16.00
17.00	01700	SOCIAL SERVICE	0	26,719			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	100		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	26,209,952	14,272	100		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	14,413,967	2,524	0		33.00
40.00	04000	SUBPROVIDER - IPF	30,957,832	5,300	0		40.00
44.00	04400	SKILLED NURSING FACILITY	3,878,425	4,623	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	30,406,145	0	0		50.00
51.00	05100	RECOVERY ROOM	3,130,379	0	0		51.00
53.00	05300	ANESTHESIOLOGY	3,302,370	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,175,916	0	0		54.00
54.01	03630	ULTRA SOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	18,262,740	0	0		59.00
60.00	06000	LABORATORY	52,289,561	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,399,853	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	11,469,460	0	0		65.00
66.00	06600	PHYSICAL THERAPY	3,534,530	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,617,813	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	200,967	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	3,125,356	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,950,381	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,060,682	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,509,499	0	0		73.00
74.00	07400	RENAL DIALYSIS	1,282,924	0	0		74.00
76.00	03950	MISC ANCILLARY	0	0	0		76.00
76.01	03951	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	447,706	0	0		76.02
76.03	03952	WOUND CARE	3,953,416	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	133,124	0	0		90.00
91.00	09100	EMERGENCY	42,649,562	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	423,362,560	26,719	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	MEALS ON WHEELS	0	0	0		194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,556,900	1,425,020	572,773		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003677	53.333583	5,727.730000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	405,976	18,867	1,375		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000959	0.706127	13.750000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet B-1 | Date/Time Prepared: 10/30/2019 3:37 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ROTATIONS)		
		16.00	17.00	22.00		
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet C Part I Date/Time Prepared: 10/30/2019 3:37 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,508,138		14,508,138	0	14,508,138	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	6,064,832		6,064,832	0	6,064,832	33.00
40.00	04000	SUBPROVIDER - IPF	4,686,761		4,686,761	0	4,686,761	40.00
44.00	04400	SKILLED NURSING FACILITY	3,614,553		3,614,553	0	3,614,553	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,269,787		4,269,787	0	4,269,787	50.00
51.00	05100	RECOVERY ROOM	1,061,392		1,061,392	0	1,061,392	51.00
53.00	05300	ANESTHESIOLOGY	1,640,316		1,640,316	0	1,640,316	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,996,277		5,996,277	0	5,996,277	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	3,157,458		3,157,458	0	3,157,458	59.00
60.00	06000	LABORATORY	6,324,185		6,324,185	0	6,324,185	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	317,904		317,904	0	317,904	62.00
65.00	06500	RESPIRATORY THERAPY	1,751,985	0	1,751,985	0	1,751,985	65.00
66.00	06600	PHYSICAL THERAPY	1,311,547	0	1,311,547	0	1,311,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	785,367	0	785,367	0	785,367	67.00
68.00	06800	SPEECH PATHOLOGY	155,326	0	155,326	0	155,326	68.00
69.00	06900	ELECTROCARDIOLOGY	254,557		254,557	0	254,557	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,523,942		1,523,942	0	1,523,942	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,455,452		4,455,452	0	4,455,452	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,090,245		7,090,245	0	7,090,245	73.00
74.00	07400	RENAL DIALYSIS	514,690		514,690	0	514,690	74.00
76.00	03950	MISC ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	0		0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	786,470		786,470	0	786,470	76.02
76.03	03952	WOUND CARE	2,321,591		2,321,591	0	2,321,591	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	236,415		236,415	0	236,415	90.00
91.00	09100	EMERGENCY	6,701,314		6,701,314	0	6,701,314	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,491,218		1,491,218		1,491,218	92.00
200.00		Subtotal (see instructions)	81,021,722	0	81,021,722	0	81,021,722	200.00
201.00		Less Observation Beds	1,491,218		1,491,218		1,491,218	201.00
202.00		Total (see instructions)	79,530,504	0	79,530,504	0	79,530,504	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet C Part I Date/Time Prepared: 10/30/2019 3:37 pm

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		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,359,682		21,359,682			30.00
33.00	03300	BURN INTENSIVE CARE UNIT	14,413,967		14,413,967			33.00
40.00	04000	SUBPROVIDER - IPF	30,957,832		30,957,832			40.00
44.00	04400	SKILLED NURSING FACILITY	3,878,425		3,878,425			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,962,438	17,443,707	30,406,145	0.140425	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,538,780	1,591,599	3,130,379	0.339062	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,603,066	1,699,304	3,302,370	0.496709	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,336,634	46,839,282	62,175,916	0.096441	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	7,839,191	10,423,549	18,262,740	0.172891	0.000000	59.00
60.00	06000	LABORATORY	21,908,971	30,380,590	52,289,561	0.120945	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,225,456	174,397	1,399,853	0.227098	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	9,641,184	1,828,276	11,469,460	0.152752	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,469,094	65,436	3,534,530	0.371067	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,567,727	50,086	3,617,813	0.217083	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	194,058	6,909	200,967	0.772893	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,225,568	1,899,788	3,125,356	0.081449	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,687,005	17,263,376	28,950,381	0.052640	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,269,854	9,790,828	18,060,682	0.246693	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,607,744	15,901,755	59,509,499	0.119145	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,235,872	47,052	1,282,924	0.401185	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	27,920	419,786	447,706	1.756666	0.000000	76.02
76.03	03952	WOUND CARE	812,058	3,141,358	3,953,416	0.587237	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15,706	117,418	133,124	1.775901	0.000000	90.00
91.00	09100	EMERGENCY	8,597,288	34,052,274	42,649,562	0.157125	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,162,609	3,687,661	4,850,270	0.307451	0.000000	92.00
200.00		Subtotal (see instructions)	226,538,129	196,824,431	423,362,560			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	226,538,129	196,824,431	423,362,560			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet C Part I Date/Time Prepared: 10/30/2019 3:37 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		33.00
40.00	04000	SUBPROVIDER - IPF		40.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.140425	50.00
51.00	05100	RECOVERY ROOM	0.339062	51.00
53.00	05300	ANESTHESIOLOGY	0.496709	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096441	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.172891	59.00
60.00	06000	LABORATORY	0.120945	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.227098	62.00
65.00	06500	RESPIRATORY THERAPY	0.152752	65.00
66.00	06600	PHYSICAL THERAPY	0.371067	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.217083	67.00
68.00	06800	SPEECH PATHOLOGY	0.772893	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081449	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052640	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.246693	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119145	73.00
74.00	07400	RENAL DIALYSIS	0.401185	74.00
76.00	03950	MISC ANCILLARY	0.000000	76.00
76.01	03951	SLEEP LAB	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.756666	76.02
76.03	03952	WOUND CARE	0.587237	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	1.775901	90.00
91.00	09100	EMERGENCY	0.157125	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.307451	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet C Part I Date/Time Prepared: 10/30/2019 3:37 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,508,138		14,508,138	0	14,508,138	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	6,064,832		6,064,832	0	6,064,832	33.00
40.00	04000	SUBPROVIDER - IPF	4,686,761		4,686,761	0	4,686,761	40.00
44.00	04400	SKILLED NURSING FACILITY	3,614,553		3,614,553	0	3,614,553	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,269,787		4,269,787	0	4,269,787	50.00
51.00	05100	RECOVERY ROOM	1,061,392		1,061,392	0	1,061,392	51.00
53.00	05300	ANESTHESIOLOGY	1,640,316		1,640,316	0	1,640,316	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,996,277		5,996,277	0	5,996,277	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	3,157,458		3,157,458	0	3,157,458	59.00
60.00	06000	LABORATORY	6,324,185		6,324,185	0	6,324,185	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	317,904		317,904	0	317,904	62.00
65.00	06500	RESPIRATORY THERAPY	1,751,985	0	1,751,985	0	1,751,985	65.00
66.00	06600	PHYSICAL THERAPY	1,311,547	0	1,311,547	0	1,311,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	785,367	0	785,367	0	785,367	67.00
68.00	06800	SPEECH PATHOLOGY	155,326	0	155,326	0	155,326	68.00
69.00	06900	ELECTROCARDIOLOGY	254,557		254,557	0	254,557	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,523,942		1,523,942	0	1,523,942	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,455,452		4,455,452	0	4,455,452	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,090,245		7,090,245	0	7,090,245	73.00
74.00	07400	RENAL DIALYSIS	514,690		514,690	0	514,690	74.00
76.00	03950	MISC ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	0		0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	786,470		786,470	0	786,470	76.02
76.03	03952	WOUND CARE	2,321,591		2,321,591	0	2,321,591	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	236,415		236,415	0	236,415	90.00
91.00	09100	EMERGENCY	6,701,314		6,701,314	0	6,701,314	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,491,218		1,491,218		1,491,218	92.00
200.00		Subtotal (see instructions)	81,021,722	0	81,021,722	0	81,021,722	200.00
201.00		Less Observation Beds	1,491,218		1,491,218		1,491,218	201.00
202.00		Total (see instructions)	79,530,504	0	79,530,504	0	79,530,504	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet C Part I Date/Time Prepared: 10/30/2019 3:37 pm

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		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,359,682		21,359,682			30.00
33.00	03300	BURN INTENSIVE CARE UNIT	14,413,967		14,413,967			33.00
40.00	04000	SUBPROVIDER - IPF	30,957,832		30,957,832			40.00
44.00	04400	SKILLED NURSING FACILITY	3,878,425		3,878,425			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,962,438	17,443,707	30,406,145	0.140425	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,538,780	1,591,599	3,130,379	0.339062	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,603,066	1,699,304	3,302,370	0.496709	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,336,634	46,839,282	62,175,916	0.096441	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	7,839,191	10,423,549	18,262,740	0.172891	0.000000	59.00
60.00	06000	LABORATORY	21,908,971	30,380,590	52,289,561	0.120945	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,225,456	174,397	1,399,853	0.227098	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	9,641,184	1,828,276	11,469,460	0.152752	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,469,094	65,436	3,534,530	0.371067	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,567,727	50,086	3,617,813	0.217083	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	194,058	6,909	200,967	0.772893	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,225,568	1,899,788	3,125,356	0.081449	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,687,005	17,263,376	28,950,381	0.052640	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,269,854	9,790,828	18,060,682	0.246693	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,607,744	15,901,755	59,509,499	0.119145	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,235,872	47,052	1,282,924	0.401185	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	27,920	419,786	447,706	1.756666	0.000000	76.02
76.03	03952	WOUND CARE	812,058	3,141,358	3,953,416	0.587237	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15,706	117,418	133,124	1.775901	0.000000	90.00
91.00	09100	EMERGENCY	8,597,288	34,052,274	42,649,562	0.157125	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,162,609	3,687,661	4,850,270	0.307451	0.000000	92.00
200.00		Subtotal (see instructions)	226,538,129	196,824,431	423,362,560			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	226,538,129	196,824,431	423,362,560			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet C Part I Date/Time Prepared: 10/30/2019 3:37 pm

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
40.00	04000	SUBPROVIDER - IPF			40.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.140425		50.00
51.00	05100	RECOVERY ROOM	0.339062		51.00
53.00	05300	ANESTHESIOLOGY	0.496709		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096441		54.00
54.01	03630	ULTRA SOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
59.00	05900	CARDIAC CATHETERIZATION	0.172891		59.00
60.00	06000	LABORATORY	0.120945		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.227098		62.00
65.00	06500	RESPIRATORY THERAPY	0.152752		65.00
66.00	06600	PHYSICAL THERAPY	0.371067		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.217083		67.00
68.00	06800	SPEECH PATHOLOGY	0.772893		68.00
69.00	06900	ELECTROCARDIOLOGY	0.081449		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052640		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.246693		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119145		73.00
74.00	07400	RENAL DIALYSIS	0.401185		74.00
76.00	03950	MISC ANCILLARY	0.000000		76.00
76.01	03951	SLEEP LAB	0.000000		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.756666		76.02
76.03	03952	WOUND CARE	0.587237		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1.775901		90.00
91.00	09100	EMERGENCY	0.157125		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.307451		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet C Part II | Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,269,787	761,732	3,508,055	0	0	50.00
51.00	05100	RECOVERY ROOM	1,061,392	262,987	798,405	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,640,316	9,847	1,630,469	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,996,277	773,465	5,222,812	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	3,157,458	142,370	3,015,088	0	0	59.00
60.00	06000	LABORATORY	6,324,185	673,059	5,651,126	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	317,904	38,412	279,492	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,751,985	248,843	1,503,142	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,311,547	295,916	1,015,631	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	785,367	118,507	666,860	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	155,326	42,873	112,453	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	254,557	47,082	207,475	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,523,942	76,668	1,447,274	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,455,452	145,471	4,309,981	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,090,245	227,210	6,863,035	0	0	73.00
74.00	07400	RENAL DIALYSIS	514,690	80,584	434,106	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	786,470	128,983	657,487	0	0	76.02
76.03	03952	WOUND CARE	2,321,591	361,627	1,959,964	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	236,415	87,139	149,276	0	0	90.00
91.00	09100	EMERGENCY	6,701,314	679,656	6,021,658	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,491,218	197,488	1,293,730	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	52,147,438	5,399,919	46,747,519	0	0	200.00
201.00		Less Observation Beds	1,491,218	197,488	1,293,730	0	0	201.00
202.00		Total (line 200 minus line 201)	50,656,220	5,202,431	45,453,789	0	0	202.00

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

Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet C Part II Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,269,787	30,406,145	0.140425		50.00
51.00	05100	RECOVERY ROOM	1,061,392	3,130,379	0.339062		51.00
53.00	05300	ANESTHESIOLOGY	1,640,316	3,302,370	0.496709		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,996,277	62,175,916	0.096441		54.00
54.01	03630	ULTRA SOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
59.00	05900	CARDIAC CATHETERIZATION	3,157,458	18,262,740	0.172891		59.00
60.00	06000	LABORATORY	6,324,185	52,289,561	0.120945		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	317,904	1,399,853	0.227098		62.00
65.00	06500	RESPIRATORY THERAPY	1,751,985	11,469,460	0.152752		65.00
66.00	06600	PHYSICAL THERAPY	1,311,547	3,534,530	0.371067		66.00
67.00	06700	OCCUPATIONAL THERAPY	785,367	3,617,813	0.217083		67.00
68.00	06800	SPEECH PATHOLOGY	155,326	200,967	0.772893		68.00
69.00	06900	ELECTROCARDIOLOGY	254,557	3,125,356	0.081449		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,523,942	28,950,381	0.052640		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,455,452	18,060,682	0.246693		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,090,245	59,509,499	0.119145		73.00
74.00	07400	RENAL DIALYSIS	514,690	1,282,924	0.401185		74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000		76.00
76.01	03951	SLEEP LAB	0	0	0.000000		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	786,470	447,706	1.756666		76.02
76.03	03952	WOUND CARE	2,321,591	3,953,416	0.587237		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	236,415	133,124	1.775901		90.00
91.00	09100	EMERGENCY	6,701,314	42,649,562	0.157125		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,491,218	4,850,270	0.307451		92.00
200.00		Subtotal (sum of lines 50 thru 199)	52,147,438	352,752,654			200.00
201.00		Less Observation Beds	1,491,218	0			201.00
202.00		Total (line 200 minus line 201)	50,656,220	352,752,654			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part I Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,921,374	0	1,921,374	15,907	120.79	30.00
33.00	BURN INTENSIVE CARE UNIT	419,851		419,851	2,524	166.34	33.00
40.00	SUBPROVIDER - IPF	414,621	0	414,621	5,300	78.23	40.00
44.00	SKILLED NURSING FACILITY	515,864		515,864	4,623	111.59	44.00
200.00	Total (lines 30 through 199)	3,271,710		3,271,710	28,354		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	2,754	332,656				30.00
33.00	BURN INTENSIVE CARE UNIT	458	76,184				33.00
40.00	SUBPROVIDER - IPF	2,882	225,459				40.00
44.00	SKILLED NURSING FACILITY	1,695	189,145				44.00
200.00	Total (lines 30 through 199)	7,789	823,444				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part II Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	761,732	30,406,145	0.025052	3,529,880	88,431	50.00
51.00	05100	RECOVERY ROOM	262,987	3,130,379	0.084011	232,092	19,498	51.00
53.00	05300	ANESTHESIOLOGY	9,847	3,302,370	0.002982	331,366	988	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	773,465	62,175,916	0.012440	3,887,596	48,362	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	142,370	18,262,740	0.007796	1,683,748	13,126	59.00
60.00	06000	LABORATORY	673,059	52,289,561	0.012872	3,848,893	49,543	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	38,412	1,399,853	0.027440	183,177	5,026	62.00
65.00	06500	RESPIRATORY THERAPY	248,843	11,469,460	0.021696	2,263,744	49,114	65.00
66.00	06600	PHYSICAL THERAPY	295,916	3,534,530	0.083721	222,236	18,606	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,507	3,617,813	0.032757	173,338	5,678	67.00
68.00	06800	SPEECH PATHOLOGY	42,873	200,967	0.213334	41,281	8,807	68.00
69.00	06900	ELECTROCARDIOLOGY	47,082	3,125,356	0.015065	241,515	3,638	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76,668	28,950,381	0.002648	3,610,869	9,562	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	145,471	18,060,682	0.008055	2,512,813	20,241	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	227,210	59,509,499	0.003818	7,749,589	29,588	73.00
74.00	07400	RENAL DIALYSIS	80,584	1,282,924	0.062813	399,340	25,084	74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	128,983	447,706	0.288098	1,932	557	76.02
76.03	03952	WOUND CARE	361,627	3,953,416	0.091472	148,576	13,591	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	87,139	133,124	0.654570	509	333	90.00
91.00	09100	EMERGENCY	679,656	42,649,562	0.015936	1,434,651	22,863	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	197,488	4,850,270	0.040717	331,543	13,499	92.00
200.00		Total (lines 50 through 199)	5,399,919	352,752,654		32,828,688	446,135	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part III Date/Time Prepared: 10/30/2019 3:37 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	
			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
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	15,907	0.00	2,754	30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	2,524	0.00	458	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	5,300	0.00	2,882	40.00
44.00	04400	SKILLED NURSING FACILITY		0	4,623	0.00	1,695	44.00
200.00		Total (lines 30 through 199)		0	28,354		7,789	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
33.00	03300	BURN INTENSIVE CARE UNIT	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part IV | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Hospital | PPS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part IV Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	30,406,145	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,130,379	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,302,370	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	62,175,916	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	18,262,740	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	52,289,561	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,399,853	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,469,460	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,534,530	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,617,813	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	200,967	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,125,356	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	28,950,381	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,060,682	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	59,509,499	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,282,924	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	447,706	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	3,953,416	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	133,124	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	42,649,562	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,850,270	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	352,752,654		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part IV | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	3,529,880	0	4,527,009	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	232,092	0	550,267	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	331,366	0	380,830	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,887,596	0	6,478,370	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,683,748	0	2,379,235	0	59.00
60.00	06000	LABORATORY	0.000000	3,848,893	0	1,784,199	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	183,177	0	68,831	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,263,744	0	370,126	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	222,236	0	6,451	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	173,338	0	5,388	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	41,281	0	750	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	241,515	0	370,148	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,610,869	0	6,048,659	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,512,813	0	3,355,638	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	7,749,589	0	3,516,308	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	399,340	0	47,051	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	1,932	0	248,720	0	76.02
76.03	03952	WOUND CARE	0.000000	148,576	0	1,271,894	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	509	0	8,070	0	90.00
91.00	09100	EMERGENCY	0.000000	1,434,651	0	2,985,173	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	331,543	0	769,328	0	92.00
200.00		Total (lines 50 through 199)		32,828,688	0	35,172,445	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part V Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.140425	4,527,009	0	0	635,705	50.00
51.00	05100	RECOVERY ROOM	0.339062	550,267	0	0	186,575	51.00
53.00	05300	ANESTHESIOLOGY	0.496709	380,830	0	0	189,162	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096441	6,478,370	0	0	624,780	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.172891	2,379,235	0	0	411,348	59.00
60.00	06000	LABORATORY	0.120945	1,784,199	0	0	215,790	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.227098	68,831	0	0	15,631	62.00
65.00	06500	RESPIRATORY THERAPY	0.152752	370,126	0	0	56,537	65.00
66.00	06600	PHYSICAL THERAPY	0.371067	6,451	0	0	2,394	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.217083	5,388	0	0	1,170	67.00
68.00	06800	SPEECH PATHOLOGY	0.772893	750	0	0	580	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081449	370,148	0	0	30,148	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052640	6,048,659	0	0	318,401	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.246693	3,355,638	0	0	827,812	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119145	3,516,308	0	23,434	418,951	73.00
74.00	07400	RENAL DIALYSIS	0.401185	47,051	0	0	18,876	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.756666	248,720	0	0	436,918	76.02
76.03	03952	WOUND CARE	0.587237	1,271,894	0	0	746,903	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.775901	8,070	0	348	14,332	90.00
91.00	09100	EMERGENCY	0.157125	2,985,173	0	0	469,045	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.307451	769,328	0	0	236,531	92.00
200.00		Subtotal (see instructions)		35,172,445	0	23,782	5,857,589	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		35,172,445	0	23,782	5,857,589	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part V Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,792	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	76.00
76.01	03951	SLEEP LAB	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02
76.03	03952	WOUND CARE	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	618	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	3,410	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	3,410	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part II | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	761,732	30,406,145	0.025052	0	0	50.00
51.00	05100	RECOVERY ROOM	262,987	3,130,379	0.084011	17,944	1,507	51.00
53.00	05300	ANESTHESIOLOGY	9,847	3,302,370	0.002982	4,077	12	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	773,465	62,175,916	0.012440	462,216	5,750	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	142,370	18,262,740	0.007796	0	0	59.00
60.00	06000	LABORATORY	673,059	52,289,561	0.012872	1,199,613	15,441	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	38,412	1,399,853	0.027440	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	248,843	11,469,460	0.021696	165,584	3,593	65.00
66.00	06600	PHYSICAL THERAPY	295,916	3,534,530	0.083721	201,854	16,899	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,507	3,617,813	0.032757	269,989	8,844	67.00
68.00	06800	SPEECH PATHOLOGY	42,873	200,967	0.213334	17,650	3,765	68.00
69.00	06900	ELECTROCARDIOLOGY	47,082	3,125,356	0.015065	67,120	1,011	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76,668	28,950,381	0.002648	17,347	46	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	145,471	18,060,682	0.008055	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	227,210	59,509,499	0.003818	1,769,257	6,755	73.00
74.00	07400	RENAL DIALYSIS	80,584	1,282,924	0.062813	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	128,983	447,706	0.288098	14,980	4,316	76.02
76.03	03952	WOUND CARE	361,627	3,953,416	0.091472	4,507	412	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	87,139	133,124	0.654570	0	0	90.00
91.00	09100	EMERGENCY	679,656	42,649,562	0.015936	379,034	6,040	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,850,270	0.000000	5,040	0	92.00
200.00		Total (lines 50 through 199)	5,202,431	352,752,654		4,596,212	74,391	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-S047
Period: From 06/01/2018 To 05/31/2019
Worksheet D Part IV
Date/Time Prepared: 10/30/2019 3:37 pm
Title XVIII
Subprovider - IPF
PPS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part IV Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	30,406,145	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,130,379	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,302,370	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	62,175,916	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	18,262,740	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	52,289,561	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,399,853	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,469,460	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,534,530	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,617,813	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	200,967	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,125,356	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	28,950,381	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,060,682	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	59,509,499	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,282,924	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	447,706	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	3,953,416	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	133,124	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	42,649,562	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,850,270	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	352,752,654		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part IV Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	17,944	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	4,077	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	462,216	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,199,613	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	165,584	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	201,854	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	269,989	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	17,650	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	67,120	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	17,347	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,769,257	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	14,980	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	4,507	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	756	0	90.00
91.00	09100	EMERGENCY	0.000000	379,034	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	5,040	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,596,212	0	756	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part V | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.140425	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.339062	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.496709	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096441	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.172891	0	0	0	0	59.00
60.00	06000	LABORATORY	0.120945	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.227098	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.152752	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.371067	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.217083	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.772893	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081449	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052640	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.246693	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119145	0	0	4,697	0	73.00
74.00	07400	RENAL DIALYSIS	0.401185	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.756666	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.587237	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.775901	756	0	0	1,343	90.00
91.00	09100	EMERGENCY	0.157125	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.307451	0	0	0	0	92.00
200.00		Subtotal (see instructions)		756	0	4,697	1,343	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		756	0	4,697	1,343	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part V | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	560		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03952	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	560		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	560		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-5356

Period:
From 06/01/2018
To 05/31/2019

Worksheet D
Part IV
Date/Time Prepared:
10/30/2019 3:37 pm

Title XVIII | Skilled Nursing Facility | PPS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part IV | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	30,406,145	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,130,379	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,302,370	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	62,175,916	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	18,262,740	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	52,289,561	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,399,853	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,469,460	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,534,530	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,617,813	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	200,967	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,125,356	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	28,950,381	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,060,682	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	59,509,499	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,282,924	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	447,706	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	3,953,416	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	133,124	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	42,649,562	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,850,270	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	352,752,654		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-5356
Period: From 06/01/2018 To 05/31/2019
Worksheet D Part IV
Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	538	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	71,000	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	380,535	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	19,821	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	441,324	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	854,532	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	963,885	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	8,026	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,892	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	99,900	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,917,810	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	47,011	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,809,274	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part I Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,921,374	0	1,921,374	15,907	120.79	30.00
33.00	BURN INTENSIVE CARE UNIT	419,851		419,851	2,524	166.34	33.00
40.00	SUBPROVIDER - IPF	414,621	0	414,621	5,300	78.23	40.00
44.00	SKILLED NURSING FACILITY	515,864		515,864	4,623	111.59	44.00
200.00	Total (lines 30 through 199)	3,271,710		3,271,710	28,354		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	832	100,497				30.00
33.00	BURN INTENSIVE CARE UNIT	137	22,789				33.00
40.00	SUBPROVIDER - IPF	544	42,557				40.00
44.00	SKILLED NURSING FACILITY	279	31,134				44.00
200.00	Total (lines 30 through 199)	1,792	196,977				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part II Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	761,732	30,406,145	0.025052	675,298	16,918	50.00
51.00	05100	RECOVERY ROOM	262,987	3,130,379	0.084011	53,460	4,491	51.00
53.00	05300	ANESTHESIOLOGY	9,847	3,302,370	0.002982	81,162	242	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	773,465	62,175,916	0.012440	987,988	12,291	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	142,370	18,262,740	0.007796	148,173	1,155	59.00
60.00	06000	LABORATORY	673,059	52,289,561	0.012872	1,159,359	14,923	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	38,412	1,399,853	0.027440	85,223	2,339	62.00
65.00	06500	RESPIRATORY THERAPY	248,843	11,469,460	0.021696	508,802	11,039	65.00
66.00	06600	PHYSICAL THERAPY	295,916	3,534,530	0.083721	45,939	3,846	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,507	3,617,813	0.032757	46,544	1,525	67.00
68.00	06800	SPEECH PATHOLOGY	42,873	200,967	0.213334	4,562	973	68.00
69.00	06900	ELECTROCARDIOLOGY	47,082	3,125,356	0.015065	55,675	839	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76,668	28,950,381	0.002648	389,134	1,030	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	145,471	18,060,682	0.008055	178,363	1,437	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	227,210	59,509,499	0.003818	2,118,649	8,089	73.00
74.00	07400	RENAL DIALYSIS	80,584	1,282,924	0.062813	118,768	7,460	74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	128,983	447,706	0.288098	0	0	76.02
76.03	03952	WOUND CARE	361,627	3,953,416	0.091472	37,188	3,402	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	87,139	133,124	0.654570	1,449	948	90.00
91.00	09100	EMERGENCY	679,656	42,649,562	0.015936	479,006	7,633	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	197,488	4,850,270	0.040717	49,375	2,010	92.00
200.00		Total (lines 50 through 199)	5,399,919	352,752,654		7,224,117	102,590	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part III Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	15,907	0.00	832	30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	2,524	0.00	137	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	5,300	0.00	544	40.00
44.00	04400	SKILLED NURSING FACILITY		0	4,623	0.00	279	44.00
200.00		Total (lines 30 through 199)		0	28,354		1,792	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
33.00	03300	BURN INTENSIVE CARE UNIT	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part IV Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Hospital | PPS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part IV Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	30,406,145	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,130,379	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,302,370	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	62,175,916	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	18,262,740	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	52,289,561	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,399,853	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,469,460	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,534,530	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,617,813	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	200,967	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,125,356	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	28,950,381	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,060,682	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	59,509,499	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,282,924	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	447,706	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	3,953,416	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	133,124	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	42,649,562	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,850,270	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	352,752,654		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part IV | Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	675,298	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	53,460	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	81,162	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	987,988	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	148,173	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,159,359	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	85,223	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	508,802	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	45,939	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	46,544	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	4,562	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	55,675	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	389,134	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	178,363	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,118,649	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	118,768	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	37,188	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	1,449	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	479,006	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	49,375	0	0	0	92.00
200.00		Total (lines 50 through 199)		7,224,117	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part V Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.140425	0	0	741,157	0	50.00
51.00	05100	RECOVERY ROOM	0.339062	0	0	112,932	0	51.00
53.00	05300	ANESTHESIOLOGY	0.496709	0	0	101,521	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096441	0	0	2,048,308	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.172891	0	0	156,926	0	59.00
60.00	06000	LABORATORY	0.120945	0	0	1,272,126	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.227098	0	0	14,294	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.152752	0	0	101,638	0	65.00
66.00	06600	PHYSICAL THERAPY	0.371067	0	0	3,682	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.217083	0	0	1,178	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.772893	0	0	3,008	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081449	0	0	95,700	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052640	0	0	271,499	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.246693	0	0	207,404	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119145	0	0	643,589	0	73.00
74.00	07400	RENAL DIALYSIS	0.401185	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.756666	0	0	3,329	0	76.02
76.03	03952	WOUND CARE	0.587237	0	0	123,386	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.775901	0	0	4,764	0	90.00
91.00	09100	EMERGENCY	0.157125	0	0	2,281,547	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.307451	0	0	224,315	0	92.00
200.00		Subtotal (see instructions)		0	0	8,412,303	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	8,412,303	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part V Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	104,077		50.00
51.00	05100	RECOVERY ROOM	0	38,291		51.00
53.00	05300	ANESTHESIOLOGY	0	50,426		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	197,541		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	0	27,131		59.00
60.00	06000	LABORATORY	0	153,857		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,246		62.00
65.00	06500	RESPIRATORY THERAPY	0	15,525		65.00
66.00	06600	PHYSICAL THERAPY	0	1,366		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	256		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,325		68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,795		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,292		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	51,165		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	76,680		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	5,848		76.02
76.03	03952	WOUND CARE	0	72,457		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	8,460		90.00
91.00	09100	EMERGENCY	0	358,488		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	68,966		92.00
200.00		Subtotal (see instructions)	0	1,258,192		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,258,192		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part II Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	761,732	30,406,145	0.025052	0	0	50.00
51.00	05100	RECOVERY ROOM	262,987	3,130,379	0.084011	0	0	51.00
53.00	05300	ANESTHESIOLOGY	9,847	3,302,370	0.002982	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	773,465	62,175,916	0.012440	78,549	977	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	142,370	18,262,740	0.007796	0	0	59.00
60.00	06000	LABORATORY	673,059	52,289,561	0.012872	308,683	3,973	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	38,412	1,399,853	0.027440	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	248,843	11,469,460	0.021696	36,995	803	65.00
66.00	06600	PHYSICAL THERAPY	295,916	3,534,530	0.083721	19,774	1,655	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,507	3,617,813	0.032757	24,451	801	67.00
68.00	06800	SPEECH PATHOLOGY	42,873	200,967	0.213334	780	166	68.00
69.00	06900	ELECTROCARDIOLOGY	47,082	3,125,356	0.015065	13,301	200	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76,668	28,950,381	0.002648	8,804	23	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	145,471	18,060,682	0.008055	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	227,210	59,509,499	0.003818	348,442	1,330	73.00
74.00	07400	RENAL DIALYSIS	80,584	1,282,924	0.062813	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	128,983	447,706	0.288098	0	0	76.02
76.03	03952	WOUND CARE	361,627	3,953,416	0.091472	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	87,139	133,124	0.654570	291	190	90.00
91.00	09100	EMERGENCY	679,656	42,649,562	0.015936	168,985	2,693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,850,270	0.000000	126	0	92.00
200.00		Total (lines 50 through 199)	5,202,431	352,752,654		1,009,181	12,811	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-S047

Period:
From 06/01/2018
To 05/31/2019

Worksheet D
Part IV
Date/Time Prepared:
10/30/2019 3:37 pm

Title XIX | Subprovider - IPF | PPS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part IV | Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	30,406,145	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,130,379	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,302,370	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	62,175,916	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	18,262,740	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	52,289,561	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,399,853	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,469,460	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,534,530	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,617,813	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	200,967	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,125,356	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	28,950,381	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,060,682	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	59,509,499	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,282,924	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	447,706	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	3,953,416	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	133,124	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	42,649,562	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,850,270	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	352,752,654		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D Part IV Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	78,549	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	308,683	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	36,995	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	19,774	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	24,451	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	780	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	13,301	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	8,804	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	348,442	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	291	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	168,985	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	126	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,009,181	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-5356

Period:
From 06/01/2018
To 05/31/2019

Worksheet D
Part IV
Date/Time Prepared:
10/30/2019 3:37 pm

Title XIX | Skilled Nursing Facility | PPS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-5356

Period: From 06/01/2018 To 05/31/2019

Worksheet D
Part IV
Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	30,406,145	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,130,379	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,302,370	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	62,175,916	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	18,262,740	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	52,289,561	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,399,853	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,469,460	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,534,530	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,617,813	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	200,967	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,125,356	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	28,950,381	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,060,682	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	59,509,499	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,282,924	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	447,706	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	3,953,416	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	133,124	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	42,649,562	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,850,270	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	352,752,654		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-5356

Period:
From 06/01/2018
To 05/31/2019

Worksheet D
Part IV
Date/Time Prepared:
10/30/2019 3:37 pm

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	2,972	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	39,217	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	62,303	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	159,376	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	88,669	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	121,740	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	780	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,252	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	23,594	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	513,289	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	6,974	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,021,166	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-1 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,907	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,907	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)	14,272	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,754	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,508,138	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)	14,508,138	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	14,508,138	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	912.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,511,813	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,511,813	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-1 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	6,064,832	2,524	2,402.87	458	1,100,514	45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,741,965	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,354,292	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)	408,840	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	446,135	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	854,975	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,499,317	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,635	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	912.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,491,218	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-1 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,921,374	14,508,138	0.132434	1,491,218	197,488	90.00
91.00	Nursing School cost	0	14,508,138	0.000000	1,491,218	0	91.00
92.00	Allied health cost	0	14,508,138	0.000000	1,491,218	0	92.00
93.00	All other Medical Education	0	14,508,138	0.000000	1,491,218	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047 Component CCN: 15-S047	Period: From 06/01/2018 To 05/31/2019	Worksheet D-1 Date/Time Prepared: 10/30/2019 3:37 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,300	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,300	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,300	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,882	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,686,761	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,686,761	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,686,761	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	884.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,548,524	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,548,524	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-1 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	677,465	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,225,989	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)	225,459	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	74,391	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	299,850	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,926,139	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-1 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	414,621	4,686,761	0.088466	0	0	90.00
91.00	Nursing School cost	0	4,686,761	0.000000	0	0	91.00
92.00	Allied health cost	0	4,686,761	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,686,761	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047 Component CCN: 15-5356	Period: From 06/01/2018 To 05/31/2019	Worksheet D-1 Date/Time Prepared: 10/30/2019 3:37 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,623	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,623	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)	4,623	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,695	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,614,553	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,614,553	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,614,553	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-1 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	3,614,553	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	781.86	71.00
72.00	Program routine service cost (line 9 x line 71)	1,325,253	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,325,253	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,325,253	83.00
84.00	Program inpatient ancillary services (see instructions)	919,157	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,244,410	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-1 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Skilled Nursing Facility | PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-1 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,907	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,907	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)	14,272	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)	832	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,508,138	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)	14,508,138	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	14,508,138	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	912.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	758,834	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)	758,834	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-1 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	6,064,832	2,524	2,402.87	137	329,193	45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,026,089	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,114,116	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)	123,286	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	102,590	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	225,876	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,888,240	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,635	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	912.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,491,218	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-1 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,921,374	14,508,138	0.132434	1,491,218	197,488	90.00
91.00	Nursing School cost	0	14,508,138	0.000000	1,491,218	0	91.00
92.00	Allied health cost	0	14,508,138	0.000000	1,491,218	0	92.00
93.00	All other Medical Education	0	14,508,138	0.000000	1,491,218	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047 Component CCN: 15-S047	Period: From 06/01/2018 To 05/31/2019	Worksheet D-1 Date/Time Prepared: 10/30/2019 3:37 pm
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,300	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,300	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,300	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)	544	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,686,761	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,686,761	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,686,761	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	884.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	481,054	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)	481,054	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-1 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	133,977	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	615,031	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)	42,557	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	12,811	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	55,368	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	559,663	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0047
Component CCN: 15-S047

Period:
From 06/01/2018
To 05/31/2019

Worksheet D-1
Date/Time Prepared:
10/30/2019 3:37 pm

Title XIX | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	414,621	4,686,761	0.088466	0	0	90.00
91.00	Nursing School cost	0	4,686,761	0.000000	0	0	91.00
92.00	Allied health cost	0	4,686,761	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,686,761	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047 Component CCN: 15-5356	Period: From 06/01/2018 To 05/31/2019	Worksheet D-1 Date/Time Prepared: 10/30/2019 3:37 pm
	Title XIX	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,623	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,623	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)	4,623	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)	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
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,614,553	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,614,553	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,614,553	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-1 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	3,614,553	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	781.86	71.00
72.00	Program routine service cost (line 9 x line 71)	218,139	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	218,139	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	515,864	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	111.59	76.00
77.00	Program capital-related costs (line 9 x line 76)	31,134	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	187,005	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	187,005	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	31,134	83.00
84.00	Program inpatient ancillary services (see instructions)	255,468	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	286,602	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047 Component CCN: 15-5356	Period: From 06/01/2018 To 05/31/2019	Worksheet D-1 Date/Time Prepared: 10/30/2019 3:37 pm
	Title XIX	Skilled Nursing Facility	PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-3 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,247,345		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		2,484,758		33.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.140425	3,529,880	495,683	50.00
51.00	05100	RECOVERY ROOM	0.339062	232,092	78,694	51.00
53.00	05300	ANESTHESIOLOGY	0.496709	331,366	164,592	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096441	3,887,596	374,924	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.172891	1,683,748	291,105	59.00
60.00	06000	LABORATORY	0.120945	3,848,893	465,504	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.227098	183,177	41,599	62.00
65.00	06500	RESPIRATORY THERAPY	0.152752	2,263,744	345,791	65.00
66.00	06600	PHYSICAL THERAPY	0.371067	222,236	82,464	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.217083	173,338	37,629	67.00
68.00	06800	SPEECH PATHOLOGY	0.772893	41,281	31,906	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081449	241,515	19,671	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052640	3,610,869	190,076	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.246693	2,512,813	619,893	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119145	7,749,589	923,325	73.00
74.00	07400	RENAL DIALYSIS	0.401185	399,340	160,209	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.756666	1,932	3,394	76.02
76.03	03952	WOUND CARE	0.587237	148,576	87,249	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.775901	509	904	90.00
91.00	09100	EMERGENCY	0.157125	1,434,651	225,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.307451	331,543	101,933	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		32,828,688	4,741,965	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)		32,828,688		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-3 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
40.00	04000	SUBPROVIDER - IPF		10,200,994		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.140425	0	0	50.00
51.00	05100	RECOVERY ROOM	0.339062	17,944	6,084	51.00
53.00	05300	ANESTHESIOLOGY	0.496709	4,077	2,025	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096441	462,216	44,577	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.172891	0	0	59.00
60.00	06000	LABORATORY	0.120945	1,199,613	145,087	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.227098	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.152752	165,584	25,293	65.00
66.00	06600	PHYSICAL THERAPY	0.371067	201,854	74,901	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.217083	269,989	58,610	67.00
68.00	06800	SPEECH PATHOLOGY	0.772893	17,650	13,642	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081449	67,120	5,467	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052640	17,347	913	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.246693	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119145	1,769,257	210,798	73.00
74.00	07400	RENAL DIALYSIS	0.401185	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.756666	14,980	26,315	76.02
76.03	03952	WOUND CARE	0.587237	4,507	2,647	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.775901	0	0	90.00
91.00	09100	EMERGENCY	0.157125	379,034	59,556	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.307451	5,040	1,550	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,596,212	677,465	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,596,212		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-3 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.140425	538	76	50.00
51.00	05100	RECOVERY ROOM	0.339062	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.496709	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096441	71,000	6,847	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.172891	0	0	59.00
60.00	06000	LABORATORY	0.120945	380,535	46,024	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.227098	19,821	4,501	62.00
65.00	06500	RESPIRATORY THERAPY	0.152752	441,324	67,413	65.00
66.00	06600	PHYSICAL THERAPY	0.371067	854,532	317,089	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.217083	963,885	209,243	67.00
68.00	06800	SPEECH PATHOLOGY	0.772893	8,026	6,203	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081449	4,892	398	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052640	99,900	5,259	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.246693	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119145	1,917,810	228,497	73.00
74.00	07400	RENAL DIALYSIS	0.401185	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.756666	0	0	76.02
76.03	03952	WOUND CARE	0.587237	47,011	27,607	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.775901	0	0	90.00
91.00	09100	EMERGENCY	0.157125	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.307451	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,809,274	919,157	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,809,274		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-3 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,065,284		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		840,964		33.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.140425	675,298	94,829	50.00
51.00	05100	RECOVERY ROOM	0.339062	53,460	18,126	51.00
53.00	05300	ANESTHESIOLOGY	0.496709	81,162	40,314	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096441	987,988	95,283	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.172891	148,173	25,618	59.00
60.00	06000	LABORATORY	0.120945	1,159,359	140,219	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.227098	85,223	19,354	62.00
65.00	06500	RESPIRATORY THERAPY	0.152752	508,802	77,721	65.00
66.00	06600	PHYSICAL THERAPY	0.371067	45,939	17,046	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.217083	46,544	10,104	67.00
68.00	06800	SPEECH PATHOLOGY	0.772893	4,562	3,526	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081449	55,675	4,535	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052640	389,134	20,484	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.246693	178,363	44,001	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119145	2,118,649	252,426	73.00
74.00	07400	RENAL DIALYSIS	0.401185	118,768	47,648	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.756666	0	0	76.02
76.03	03952	WOUND CARE	0.587237	37,188	21,838	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.775901	1,449	2,573	90.00
91.00	09100	EMERGENCY	0.157125	479,006	75,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.307451	49,375	15,180	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,224,117	1,026,089	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		7,224,117		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-3 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
40.00	04000	SUBPROVIDER - IPF		1,494,845		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.140425	0	0	50.00
51.00	05100	RECOVERY ROOM	0.339062	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.496709	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096441	78,549	7,575	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.172891	0	0	59.00
60.00	06000	LABORATORY	0.120945	308,683	37,334	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.227098	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.152752	36,995	5,651	65.00
66.00	06600	PHYSICAL THERAPY	0.371067	19,774	7,337	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.217083	24,451	5,308	67.00
68.00	06800	SPEECH PATHOLOGY	0.772893	780	603	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081449	13,301	1,083	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052640	8,804	463	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.246693	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119145	348,442	41,515	73.00
74.00	07400	RENAL DIALYSIS	0.401185	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.756666	0	0	76.02
76.03	03952	WOUND CARE	0.587237	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.775901	291	517	90.00
91.00	09100	EMERGENCY	0.157125	168,985	26,552	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.307451	126	39	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,009,181	133,977	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,009,181		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2018 To 05/31/2019 | Worksheet D-3 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.140425	2,972	417	50.00
51.00	05100	RECOVERY ROOM	0.339062	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.496709	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096441	39,217	3,782	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.172891	0	0	59.00
60.00	06000	LABORATORY	0.120945	62,303	7,535	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.227098	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.152752	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.371067	159,376	59,139	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.217083	88,669	19,249	67.00
68.00	06800	SPEECH PATHOLOGY	0.772893	121,740	94,092	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081449	780	64	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052640	2,252	119	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.246693	23,594	5,820	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119145	513,289	61,156	73.00
74.00	07400	RENAL DIALYSIS	0.401185	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.756666	0	0	76.02
76.03	03952	WOUND CARE	0.587237	6,974	4,095	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.775901	0	0	90.00
91.00	09100	EMERGENCY	0.157125	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.307451	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,021,166	255,468	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,021,166		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Period: From 06/01/2018 To 05/31/2019	Worksheet E Part A Date/Time Prepared: 10/30/2019 3:37 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,892,245	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,439,273	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)	187,239	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	3,901,000	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	100.91	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	8.95	5.00
6.00	FTE count for allopathic and osteopathic programs 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)	1.89	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	-6.37	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.69	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.50	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.50	12.00
13.00	Total allowable FTE count for the prior year.	0.69	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	5.29	14.00
15.00	Sum of lines 12 through 14 divided by 3.	2.16	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	2.16	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.021405	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.006759	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.006759	21.00
22.00	IME payment adjustment (see instructions)	19,663	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	14,387	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	4.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	-0.19	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)	19,663	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	14,387	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	13.08	30.00
31.00	Percentage of Medicaid patient days (see instructions)	43.47	31.00
32.00	Sum of lines 30 and 31	56.55	32.00
33.00	Allowable disproportionate share percentage (see instructions)	35.87	33.00
34.00	Disproportionate share adjustment (see instructions)	478,104	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet E Part A Date/Time Prepared: 10/30/2019 3:37 pm

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,606,994	1,655,129	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	537,133	1,101,907	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,639,040		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	7,655,564		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		7,669,951	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		530,827	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).		67,250	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		8,268,028	59.00
60.00	Primary payer payments		4,289	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		8,263,739	61.00
62.00	Deductibles billed to program beneficiaries		527,204	62.00
63.00	Coinsurance billed to program beneficiaries		13,807	63.00
64.00	Allowable bad debts (see instructions)		167,196	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		108,677	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		84,982	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		7,831,405	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		2,315	70.93
70.94	HRR adjustment amount (see instructions)		-5,763	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet E Part A Date/Time Prepared: 10/30/2019 3:37 pm

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		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)		7,827,957	71.00
71.01	Sequestration adjustment (see instructions)		156,559	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		7,324,581	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)		346,817	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,708,437	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet E Part B Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,410	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,857,589	2.00
3.00	OPPS payments	3,697,114	3.00
4.00	Outlier payment (see instructions)	97,030	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,410	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	23,782	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)	23,782	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	23,782	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	20,372	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	3,410	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)	3,794,144	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	10,421	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	628,456	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,158,677	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	29,011	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,187,688	30.00
31.00	Primary payer payments	163	31.00
32.00	Subtotal (line 30 minus line 31)	3,187,525	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	255,718	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	166,217	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	177,169	36.00
37.00	Subtotal (see instructions)	3,353,742	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,353,742	40.00
40.01	Sequestration adjustment (see instructions)	67,075	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,369,958	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-83,291	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047 Component CCN: 15-S047	Period: From 06/01/2018 To 05/31/2019	Worksheet E Part B Date/Time Prepared: 10/30/2019 3:37 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	560	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,343	2.00
3.00	OPPS payments	193	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	560	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	4,697	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)	4,697	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	4,697	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	4,137	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)	560	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)	193	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	11	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	742	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	742	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	742	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	742	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	742	40.00
40.01	Sequestration adjustment (see instructions)	15	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,099	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-372	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet E-1 Part I Date/Time Prepared: 10/30/2019 3:37 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		7,324,581		3,369,958	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)		7,324,581		3,369,958	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		346,817		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		83,291	6.02
7.00	Total Medicare program liability (see instructions)		7,671,398		3,286,667	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,283,703		1,099	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,283,703		1,099	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		845		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		372	6.02
7.00	Total Medicare program liability (see instructions)		2,284,548		727	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0047
Component CCN: 15-5356

Period:
From 06/01/2018
To 05/31/2019

Worksheet E-1
Part I
Date/Time Prepared:
10/30/2019 3:37 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		572,936		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		572,936		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		572,936		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0047	Period: From 06/01/2018 To 05/31/2019	Worksheet E-1 Part II Date/Time Prepared: 10/30/2019 3:37 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047 Component CCN: 15-S047	Period: From 06/01/2018 To 05/31/2019	Worksheet E-3 Part II Date/Time Prepared: 10/30/2019 3:37 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,526,959	1.00
2.00	Net IPF PPS Outlier Payments	5,977	2.00
3.00	Net IPF PPS ECT Payments	1,207	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	14.520548	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,534,143	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,534,143	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,534,143	18.00
19.00	Deductibles	171,164	19.00
20.00	Subtotal (line 18 minus line 19)	2,362,979	20.00
21.00	Coinsurance	32,663	21.00
22.00	Subtotal (line 20 minus line 21)	2,330,316	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1,316	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	855	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,316	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,331,171	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,331,171	31.00
31.01	Sequestration adjustment (see instructions)	46,623	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	2,283,703	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	845	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	5,977	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047 Component CCN: 15-5356	Period: From 06/01/2018 To 05/31/2019	Worksheet E-3 Part VI Date/Time Prepared: 10/30/2019 3:37 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	689,080	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	689,080	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	104,451	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	584,629	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	584,629	15.00
15.01	Sequestration adjustment (see instructions)	11,693	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	572,936	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet E-3 Part VII Date/Time Prepared: 10/30/2019 3:37 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		1,258,192	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	1,258,192	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	1,258,192	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	7,224,117	8,412,303	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	7,224,117	8,412,303	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	7,224,117	8,412,303	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	7,224,117	7,154,111	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	1,258,192	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	1,258,192	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	1,258,192	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	1,258,192	36.00
37.00	ELIMINATE SETTLEMENT	0	-1,258,192	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047 Component CCN: 15-S047	Period: From 06/01/2018 To 05/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 10/30/2019 3:37 pm
	Title XIX	Subprovider - IPF	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	1,009,181	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,009,181	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,009,181	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,009,181	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047 Component CCN: 15-5356	Period: From 06/01/2018 To 05/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 10/30/2019 3:37 pm
	Title XIX	Skilled Nursing Facility	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	286,602		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	286,602	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	286,602	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	1,021,166	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,021,166	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,021,166	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	734,564	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	286,602	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	286,602	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	286,602	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	286,602	0	36.00
37.00	SETTLEMENT ADJ	-286,602	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet E-4 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			7.63	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-6.94	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			0.69	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.50	6.00
7.00	Enter the lesser of line 5 or line 6			0.50	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.	0.50	0.00	0.50	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.50	0.00	0.50	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.50	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.69	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	5.29	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	2.16	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	2.16	0.00		17.00
18.00	Per resident amount	102,134.57	96,712.47		18.00
19.00	Approved amount for resident costs	220,611	0	220,611	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			5.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			101,570.05	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)			220,611	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	6,094	4,131		26.00
27.00	Total Inpatient Days (see instructions)	22,096	22,096		27.00
28.00	Ratio of inpatient days to total inpatient days	0.275797	0.186957		28.00
29.00	Program direct GME amount	60,844	41,245		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		5,828		30.00
31.00	Net Program direct GME amount			96,261	31.00

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

Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet E-4 | Date/Time Prepared: 10/30/2019 3:37 pm

Title XVIII | Hospital | PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	1,282,924	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	13,594,614	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)	4,289	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	13,590,325	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	5,862,902	42.00
43.00	Primary payer payments (see instructions)	163	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	5,862,739	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	19,453,064	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.698621	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.301379	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	96,261	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	67,250	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	29,011	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet G | Date/Time Prepared: 10/30/2019 3:37 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-978,825	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	39,972,210	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-15,399,728	0	0	0	6.00
7.00	Inventory	3,053,590	0	0	0	7.00
8.00	Prepaid expenses	1,650,580	0	0	0	8.00
9.00	Other current assets	569,640	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	28,867,467	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,010,000	0	0	0	12.00
13.00	Land improvements	412,126	0	0	0	13.00
14.00	Accumulated depreciation	-316,600	0	0	0	14.00
15.00	Buildings	28,363,799	0	0	0	15.00
16.00	Accumulated depreciation	-20,111,861	0	0	0	16.00
17.00	Leasehold improvements	23,328,864	0	0	0	17.00
18.00	Accumulated depreciation	-8,336,829	0	0	0	18.00
19.00	Fixed equipment	1,569,517	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	22,591,480	0	0	0	23.00
24.00	Accumulated depreciation	-17,595,552	0	0	0	24.00
25.00	Minor equipment depreciable	8,355,514	0	0	0	25.00
26.00	Accumulated depreciation	-7,245,004	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	32,025,454	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	8,923,261	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,923,261	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	69,816,182	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,901,536	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,174,793	0	0	0	38.00
39.00	Payroll taxes payable	245,940	0	0	0	39.00
40.00	Notes and loans payable (short term)	238,034	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	44,481,087	0	0	0	43.00
44.00	Other current liabilities	1,689,510	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	50,730,900	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	-1	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)	-1	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	50,730,899	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	19,085,283				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	19,085,283	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	69,816,182	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet G-1 | Date/Time Prepared: 10/30/2019 3:37 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		33,547,476		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-14,462,193				2.00
3.00	Total (sum of line 1 and line 2)		19,085,283		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		19,085,283		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		19,085,283		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet G-2 Parts I & II | Date/Time Prepared: 10/30/2019 3:37 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	21,658,560		21,658,560	1.00
2.00	SUBPROVIDER - IPF	28,566,134		28,566,134	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	3,878,425		3,878,425	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)	54,103,119		54,103,119	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	14,494,928		14,494,928	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)	14,494,928		14,494,928	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	68,598,047		68,598,047	17.00
18.00	Ancillary services	148,039,073	158,985,517	307,024,590	18.00
19.00	Outpatient services	9,868,123	37,871,802	47,739,925	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	226,505,243	196,857,319	423,362,562	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		85,150,651		29.00
30.00	ROUNDING ADJUSTMENT	6			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)		6		36.00
37.00	ROUNDING ADJUSTMENT	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)		85,150,657		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2018 To 05/31/2019 | Worksheet G-3 | Date/Time Prepared: 10/30/2019 3:37 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	423,362,562	1.00
2.00	Less contractual allowances and discounts on patients' accounts	352,771,039	2.00
3.00	Net patient revenues (line 1 minus line 2)	70,591,523	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	85,150,657	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-14,559,134	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISC INCOME	96,941	24.00
25.00	Total other income (sum of lines 6-24)	96,941	25.00
26.00	Total (line 5 plus line 25)	-14,462,193	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)	-14,462,193	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0047	Period: From 06/01/2018 To 05/31/2019	Worksheet L Parts I-III Date/Time Prepared: 10/30/2019 3:37 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	428,328	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	44,846	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)	46.16	3.00
4.00	Number of interns & residents (see instructions)	2.16	4.00
5.00	Indirect medical education percentage (see instructions)	1.33	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)	5,697	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	13.08	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	43.47	8.00
9.00	Sum of lines 7 and 8	56.55	9.00
10.00	Allowable disproportionate share percentage (see instructions)	12.13	10.00
11.00	Disproportionate share adjustment (see instructions)	51,956	11.00
12.00	Total prospective capital payments (see instructions)	530,827	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00