

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: 14-0011	Period: From 04/01/2018 To 03/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/16/2019 11:01 am
--	-----------------------	---	---

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 8/16/2019	Time: 11:01 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HERRIN HOSPITAL (14-0011) for the cost reporting period beginning 04/01/2018 and ending 03/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-2,892,244	93,379	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	37,690	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-2,854,554	93,379	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: 14-0011		Period: From 04/01/2018 To 03/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/16/2019 10:56 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 201 S. 14TH STREET			PO Box:				1.00	
2.00	City: HERRIN			State: IL		Zip Code: 62948		County:	
		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			HERRIN HOSPITAL	140011	16060	1	07/01/1966	N
4.00	Subprovider - IPF							P	0
5.00	Subprovider - IRF			HERRIN HOSPITAL ACUTE REHAB	14T011	16060	5	04/01/1998	N
6.00	Subprovider - (Other)							P	0
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						04/01/2018	03/31/2019	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	
							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		
22.01	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		
22.02	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		
22.03	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	
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.					1	N		
				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.			754	139	0	0	2,558	165

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/16/2019 10:56 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	382	95	0	0	548		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	09/15/2014	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.					1		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.					04/01/2018	03/31/2019	38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
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
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
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		
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.							
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.							
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				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: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/16/2019 10:56 am

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
	Unweighted FTEs Nonprovider Site		Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/16/2019 10:56 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00	
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0011	Period: From 04/01/2018 To 03/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/16/2019 10:56 am
			1.00	
Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00
		V	XIX	
		1.00	2.00	
Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	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.	N	N	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.	N	N	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.	N	N	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.	N	N	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
		1.00	2.00	3.00
				Respiratory
				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: 14-0011	Period: From 04/01/2018 To 03/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/16/2019 10:56 am	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,488,094	0	0	
		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		Y	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		14H124	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0011		Period: From 04/01/2018 To 03/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/16/2019 10:56 am	
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: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 06101					
142.00	Street: 1239 E. MAIN STREET	PO Box: 3988							
143.00	City: CARBONDALE	State: IL		Zip Code: 62902-3988					
								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.							N	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.								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	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	N	157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF	N	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	160.00	
161.00	CMHC		N	N	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)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					10/01/2018	12/31/2018	170.00	
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0	171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/16/2019 10:56 am

		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N	Date	Y/N
		1.00	2.00	3.00
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	08/08/2019	Y
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
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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/16/2019 10:56 am

		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		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
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.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
			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.		N		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.	LUANNE	WARREN		41.00
42.00	Enter the employer/company name of the cost report preparer.	SOUTHERN ILLINOIS HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-457-5200	LUANNE.WARREN@SIH.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/16/2019 10:56 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT DIRECTOR	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

Health Financial Systems		HERRIN HOSPITAL		Non-CMS HFS Worksheet	
HFS Supplemental Information		Provider CCN: 14-0011	Period: From 04/01/2018 To 03/31/2019	Worksheet S-2 Part IX Date/Time Prepared: 8/16/2019 10:56 am	
			Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	N	N		1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	N	N		2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	N	N		3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N		3.01
			Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N		4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N		5.00
			Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	N	N		6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	N	N		7.00
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N		8.00
FQHC					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N		9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/16/2019 10:56 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	77	28,105	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)		77	28,105	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		85	31,025	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	29	10,585		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		114			0	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: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/16/2019 10:56 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	11,360	803	19,177			1.00
2.00	HMO and other (see instructions)	1,488	2,723				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	204	728				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)	11,360	803	19,177			7.00
8.00	INTENSIVE CARE UNIT	1,366	90	2,219			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)	12,726	893	21,396	0.00	732.07	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	4,802	297	7,103	0.00	58.23	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	790.30	27.00
28.00	Observation Bed Days		78	2,061			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	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: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/16/2019 10:56 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	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	3,238	235	6,147	1.00
2.00 HMO and other (see instructions)			414	880		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				50		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	3,238	235	6,147	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	308	14	459	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/16/2019 10:56 am

	Wkst. A Line Number	Amount Reported	Reclassificati on 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	46,697,945	0	46,697,945	1,643,821.55	28.41
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		211,811	0	211,811	4,159.91	50.92
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		3,490,139	-147,589	3,342,550	121,119.21	27.60
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		823,183	0	823,183	14,161.67	58.13
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		103,151	0	103,151	616.00	167.45
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		8,093,974	0	8,093,974	225,813.20	35.84
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,429,399	0	8,429,399		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		653,068	0	653,068		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		41,384	0	41,384		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		3,288,059	0	3,288,059		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	69,449	0	69,449	2,657.52	26.13
27.00	Administrative & General	5.00	5,048,864	0	5,048,864	144,865.91	34.85

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/16/2019 10:56 am

		Wkst. A Line Number	Amount Reported	Reclassificati on 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.)		261,036	0	261,036	781.33	334.09	28.00
29.00	Maintenance & Repairs	6.00	584,985	0	584,985	23,474.87	24.92	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	43,662	0	43,662	2,771.70	15.75	31.00
32.00	Housekeeping	9.00	1,248,577	0	1,248,577	84,815.36	14.72	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,106,855	-735,404	371,451	22,880.42	16.23	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	735,404	735,404	45,297.24	16.24	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	957,670	0	957,670	28,476.47	33.63	38.00
39.00	Central Services and Supply	14.00	209,876	0	209,876	11,905.31	17.63	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	364,812	0	364,812	19,420.05	18.79	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part III
Date/Time Prepared:
8/16/2019 10:56 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	46,747,170	0	46,747,170	1,640,442.97	28.50	1.00
2.00	Excluded area salaries (see instructions)	3,490,139	-147,589	3,342,550	121,119.21	27.60	2.00
3.00	Subtotal salaries (line 1 minus line 2)	43,257,031	147,589	43,404,620	1,519,323.76	28.57	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,020,308	0	9,020,308	240,590.87	37.49	4.00
5.00	Subtotal wage-related costs (see inst.)	11,717,458	0	11,717,458	0.00	27.00	5.00
6.00	Total (sum of lines 3 thru 5)	63,994,797	147,589	64,142,386	1,759,914.63	36.45	6.00
7.00	Total overhead cost (see instructions)	9,895,786	0	9,895,786	387,346.18	25.55	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part IV
Date/Time Prepared:
8/16/2019 10:56 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	787,684	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)	3,830,164	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	75,074	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	33,527	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	114,849	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	246,880	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	446,346	16.00
TAXES			
17.00	FICA-Employers Portion Only	3,382,836	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	23,528	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	75,528	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	107,434	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,123,850	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: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part V
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	823,183	9,123,850	1.00
2.00	Hospital	823,183	9,123,850	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet S-10

Date/Time Prepared:
8/16/2019 10:56 am

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.191112	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		11,795,382	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		1,277,414	5.00
6.00	Medicaid charges		140,085,025	6.00
7.00	Medicaid cost (line 1 times line 6)		26,771,929	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)		13,699,133	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)		28,318	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		324,521	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		62,020	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)		33,702	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		11,675	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		13,732,835	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	4,213,576	873,594	5,087,170
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	805,265	873,594	1,678,859
22.00	Payments received from patients for amounts previously written off as charity care	17,581	29,409	46,990
23.00	Cost of charity care (line 21 minus line 22)	787,684	844,185	1,631,869
				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)		12,219,395	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,291,096	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,986,301	27.01
28.00	Non-Medicare bad debt expense (see instructions)		10,233,094	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,650,872	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,282,741	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		18,015,576	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet A

Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (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		4,916,091	4,916,091	835,859	5,751,950	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,138,053	3,138,053	275,064	3,413,117	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	69,449	14,770,272	14,839,721	0	14,839,721	4.00
5.01	00550	DATA PROCESSING	0	0	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	218,958	86,700	305,658	0	305,658	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,090,219	39,171	1,129,390	0	1,129,390	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	3,739,687	7,797,874	11,537,561	-197	11,537,364	5.04
6.00	00600	MAINTENANCE & REPAIRS	584,985	1,288,022	1,873,007	-65	1,872,942	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,662	471,999	515,661	0	515,661	8.00
9.00	00900	HOUSEKEEPING	1,248,577	327,943	1,576,520	0	1,576,520	9.00
10.00	01000	DIETARY	1,106,855	842,056	1,948,911	-1,294,873	654,038	10.00
11.00	01100	CAFETERIA	0	0	0	1,294,873	1,294,873	11.00
13.00	01300	NURSING ADMINISTRATION	957,670	111,635	1,069,305	0	1,069,305	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	209,876	59,105	268,981	-814	268,167	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	364,812	19,561	384,373	0	384,373	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	2,963,876	2,963,876	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,183,245	5,811,325	13,994,570	-42,566	13,952,004	30.00
31.00	03100	INTENSIVE CARE UNIT	1,651,644	444,287	2,095,931	-11,234	2,084,697	31.00
41.00	04100	SUBPROVIDER - IRF	3,342,550	1,645,231	4,987,781	-1,781	4,986,000	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,206,981	8,185,765	12,392,746	-3,045,797	9,346,949	50.00
51.00	05100	RECOVERY ROOM	682,372	43,108	725,480	0	725,480	51.00
53.00	05300	ANESTHESIOLOGY	444,128	3,256,221	3,700,349	-3,003,393	696,956	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,155,944	907,716	3,063,660	-106,105	2,957,555	54.00
56.00	05600	RADIOISOTOPE	254,090	1,117,439	1,371,529	0	1,371,529	56.00
57.00	05700	CT SCAN	443,509	446,591	890,100	-78,195	811,905	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	352,199	464,250	816,449	-82,786	733,663	58.00
60.00	06000	LABORATORY	1,880,824	4,655,327	6,536,151	323,249	6,859,400	60.00
65.00	06500	RESPIRATORY THERAPY	1,207,743	245,281	1,453,024	-76,731	1,376,293	65.00
66.00	06600	PHYSICAL THERAPY	5,399,434	1,514,484	6,913,918	0	6,913,918	66.00
69.00	06900	ELECTROCARDIOLOGY	1,036,861	790,677	1,827,538	-365,983	1,461,555	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,400,965	3,400,965	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,107,938	7,107,938	0	7,107,938	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,084,970	5,469,680	7,554,650	548,631	8,103,281	73.00
76.97	07697	CARDIAC REHABILITATION	416,883	22,411	439,294	-50	439,244	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	166,276	342,732	509,008	-28,432	480,576	90.00
91.00	09100	EMERGENCY	3,005,953	6,621,050	9,627,003	-30,480	9,596,523	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,737,260	1,737,260	-1,110,923	626,337	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,550,356	84,697,255	131,247,611	362,112	131,609,723	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	404,994	404,994	0	404,994	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
192.02	19202	REFERENCE LAB	147,589	214,523	362,112	-362,112	0	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	46,697,945	85,316,772	132,014,717	0	132,014,717	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet A

Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-229,431	5,522,519	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,845,431	6,258,548	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,115,799	13,723,922	4.00
5.01	00550	DATA PROCESSING	6,731,375	6,731,375	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-6,736	298,922	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,361,014	3,490,404	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	504,895	12,042,259	5.04
6.00	00600	MAINTENANCE & REPAIRS	-17,082	1,855,860	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	515,661	8.00
9.00	00900	HOUSEKEEPING	0	1,576,520	9.00
10.00	01000	DIETARY	0	654,038	10.00
11.00	01100	CAFETERIA	-592,438	702,435	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,069,305	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	268,167	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-62,060	322,313	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-2,963,876	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,011,313	10,940,691	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,084,697	31.00
41.00	04100	SUBPROVIDER - IRF	-1,416,333	3,569,667	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-25,559	9,321,390	50.00
51.00	05100	RECOVERY ROOM	0	725,480	51.00
53.00	05300	ANESTHESIOLOGY	0	696,956	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-63,743	2,893,812	54.00
56.00	05600	RADIOISOTOPE	0	1,371,529	56.00
57.00	05700	CT SCAN	0	811,905	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	733,663	58.00
60.00	06000	LABORATORY	-290,637	6,568,763	60.00
65.00	06500	RESPIRATORY THERAPY	-18,563	1,357,730	65.00
66.00	06600	PHYSICAL THERAPY	-101,905	6,812,013	66.00
69.00	06900	ELECTROCARDIOLOGY	-136,008	1,325,547	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,400,965	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,107,938	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,103,281	73.00
76.97	07697	CARDIAC REHABILITATION	-682	438,562	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-11,961	468,615	90.00
91.00	09100	EMERGENCY	-5,208,187	4,388,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-626,337	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,455,935	128,153,788	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-175,403	229,591	192.00
192.01	19201	VACANT SPACE	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,631,338	128,383,379	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet Non-CMS W

Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	DATA PROCESSING	00550	DATA PROCESSING	5.01
5.02	PURCHASING RECEIVING AND STORES	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	00590		5.04
6.00	MAINTENANCE & REPAIRS	00600		6.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
41.00	SUBPROVIDER - IRF	04100		41.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.97	CARDIAC REHABILITATION	07697		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	VACANT SPACE	19201		192.01
192.02	REFERENCE LAB	19202		192.02
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-6

Date/Time Prepared:
8/16/2019 10:56 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	735,404	559,469		1.00
	TOTALS		735,404	559,469		
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,400,965		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
	TOTALS		0	3,400,965		
	C - CRNA RECLASS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	2,963,876		1.00
	TOTALS		0	2,963,876		
	D - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	835,859		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	275,064		2.00
	TOTALS		0	1,110,923		
	E - CONTRAST DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	549,219		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
	TOTALS		0	549,219		
	F - REFERENCE LAB RECLASS					
1.00	LABORATORY	60.00	147,589	214,523		1.00
	TOTALS		147,589	214,523		
500.00	Grand Total: Increases		882,993	8,798,975		500.00

RECLASSIFICATIONS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-6

Date/Time Prepared:
8/16/2019 10:56 am

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00			
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	735,404	559,469	0	1.00	
	TOTALS		735,404	559,469			
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	197	0	1.00	
2.00	ADULTS & PEDIATRICS	30.00	0	42,566	0	2.00	
3.00	SUBPROVIDER - IRF	41.00	0	1,781	0	3.00	
4.00	INTENSIVE CARE UNIT	31.00	0	11,234	0	4.00	
5.00	OPERATING ROOM	50.00	0	3,035,949	0	5.00	
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	814	0	6.00	
7.00	EMERGENCY	91.00	0	30,480	0	7.00	
8.00	ANESTHESIOLOGY	53.00	0	39,517	0	8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	76,151	0	9.00	
10.00	CT SCAN	57.00	0	12,396	0	10.00	
11.00	LABORATORY	60.00	0	38,863	0	11.00	
12.00	RESPIRATORY THERAPY	65.00	0	76,731	0	12.00	
13.00	CARDIAC REHABILITATION	76.97	0	50	0	13.00	
14.00	ELECTROCARDIOLOGY	69.00	0	5,151	0	14.00	
15.00	CLINIC	90.00	0	28,432	0	15.00	
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	588	0	16.00	
17.00	MAINTENANCE & REPAIRS	6.00	0	65	0	17.00	
	TOTALS		0	3,400,965			
	C - CRNA RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	2,963,876	0	1.00	
	TOTALS		0	2,963,876			
	D - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	1,110,923	9	1.00	
2.00		0.00	0	0	9	2.00	
	TOTALS		0	1,110,923			
	E - CONTRAST DRUG RECLASS						
1.00	ELECTROCARDIOLOGY	69.00	0	360,832	0	1.00	
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,954	0	2.00	
3.00	CT SCAN	57.00	0	65,799	0	3.00	
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	82,786	0	4.00	
5.00	OPERATING ROOM	50.00	0	9,848	0	5.00	
	TOTALS		0	549,219			
	F - REFERENCE LAB RECLASS						
1.00	REFERENCE LAB	192.02	147,589	214,523	0	1.00	
	TOTALS		147,589	214,523			
500.00	Grand Total: Decreases		882,993	8,798,975		500.00	

RECLASSIFICATIONS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
8/16/2019 10:56 am

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - CAFETERIA RECLASS									
1.00	CAFETERIA	11.00	735,404	559,469	DIETARY	10.00	735,404	559,469	1.00
	TOTALS		735,404	559,469	TOTALS		735,404	559,469	
B - MEDICAL SUPPLIES CHARGED TO PATIENTS									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,400,965	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	197	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	42,566	2.00
3.00		0.00	0	0	SUBPROVIDER - IRF	41.00	0	1,781	3.00
4.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	11,234	4.00
5.00		0.00	0	0	OPERATING ROOM	50.00	0	3,035,949	5.00
6.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	814	6.00
7.00		0.00	0	0	EMERGENCY	91.00	0	30,480	7.00
8.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	39,517	8.00
9.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	76,151	9.00
10.00		0.00	0	0	CT SCAN	57.00	0	12,396	10.00
11.00		0.00	0	0	LABORATORY	60.00	0	38,863	11.00
12.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	76,731	12.00
13.00		0.00	0	0	CARDIAC REHABILITATION	76.97	0	50	13.00
14.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	5,151	14.00
15.00		0.00	0	0	CLINIC	90.00	0	28,432	15.00
16.00		0.00	0	0	DRUGS CHARGED TO PATIENTS	73.00	0	588	16.00
17.00		0.00	0	0	MAINTENANCE & REPAIRS	6.00	0	65	17.00
	TOTALS		0	3,400,965	TOTALS		0	3,400,965	
C - CRNA RECLASS									
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	2,963,876	ANESTHESIOLOGY	53.00	0	2,963,876	1.00
	TOTALS		0	2,963,876	TOTALS		0	2,963,876	
D - INTEREST RECLASS									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	835,859	INTEREST EXPENSE	113.00	0	1,110,923	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	275,064		0.00	0	0	2.00
	TOTALS		0	1,110,923	TOTALS		0	1,110,923	
E - CONTRAST DRUG RECLASS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	549,219	ELECTROCARDIOLOGY	69.00	0	360,832	1.00
2.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	29,954	2.00
3.00		0.00	0	0	CT SCAN	57.00	0	65,799	3.00
4.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	82,786	4.00
5.00		0.00	0	0	OPERATING ROOM	50.00	0	9,848	5.00
	TOTALS		0	549,219	TOTALS		0	549,219	
F - REFERENCE LAB RECLASS									
1.00	LABORATORY	60.00	147,589	214,523	REFERENCE LAB	192.02	147,589	214,523	1.00
	TOTALS		147,589	214,523	TOTALS		147,589	214,523	
500.00	Grand Total: Increases		882,993	8,798,975	Grand Total: Decreases		882,993	8,798,975	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet A-7
Part I
Date/Time Prepared:
8/16/2019 10:56 am

		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	4,318,298	766,121	0	766,121	95,299	1.00
2.00	Land Improvements	5,372,670	512,824	0	512,824	118,957	2.00
3.00	Buildings and Fixtures	86,419,831	9,932,735	0	9,932,735	840,641	3.00
4.00	Building Improvements	26,804	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	32,709,253	3,993,173	0	3,993,173	1,725,033	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	128,846,856	15,204,853	0	15,204,853	2,779,930	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	128,846,856	15,204,853	0	15,204,853	2,779,930	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	4,989,120	0				
2.00	Land Improvements	5,766,537	0				
3.00	Buildings and Fixtures	95,511,925	0				
4.00	Building Improvements	26,804	0				
5.00	Fixed Equipment	0	0				
6.00	Movable Equipment	34,977,393	0				
7.00	HIT designated Assets	0	0				
8.00	Subtotal (sum of lines 1-7)	141,271,779	0				
9.00	Reconciling Items	0	0				
10.00	Total (line 8 minus line 9)	141,271,779	0				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet A-7
Part II
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,916,091	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,138,053	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,054,144	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	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	4,916,091				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,138,053				2.00
3.00	Total (sum of lines 1-2)	0	8,054,144				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet A-7
Part III
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	106,294,385	0	106,294,385	0.752411	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	34,977,393	0	34,977,393	0.247589	0	2.00
3.00	Total (sum of lines 1-2)	141,271,778	0	141,271,778	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	5,522,519	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,258,548	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	11,781,067	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	5,522,519	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	6,258,548	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	11,781,067	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-8

Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-10,025,537			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	23,687,575			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-592,438	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	-62,036	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-2,963,876	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TELEVISION AND RADIO SERVICES	A	-497	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-8

Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	CABLE TV	A	-17,082	MAINTENANCE & REPAIRS	6.00	0	33.01
33.02	INTEREST INCOME UNRESTRICTED	B	-1,661,368	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.02
33.03	PAYMENTS FOR OUTPATIENT SERVICES	B	-5,555,700	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	NONALLOWABLE BOND EXPENSE	A	-626,337	INTEREST EXPENSE	113.00	0	33.04
33.05	PURCHASE DISCOUNTS	B	-6,736	PURCHASING RECEIVING AND STORES	5.02	0	33.05
33.06	CABLE TV	A	-960	SUBPROVIDER - IRF	41.00	0	33.06
33.07	OFFSET OF LOBBYING EXPENSES	A	-21,398	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.07
33.08	COMMUNITY DONATIONS	A	-5,763	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	LEASEHOLD REVENUE	B	-619,697	CAP REL COSTS-BLDG & FIXT	1.00	9	33.09
33.10	DEBT FORGIVENESS	A	-94,089	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.10
33.11	REAL ESTATE TAXES	A	-54,341	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.11
33.12	MEDICAID PROVIDER TAX	A	-4,957,846	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.12
33.13	MISCELLANEOUS INCOME	B	-2,596	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.13
33.14	CABLE TV	A	-298	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.14
33.15	COMMUNITY DONATIONS	A	-21	ADULTS & PEDIATRICS	30.00	0	33.15
33.16	XRAY FILM	B	-1,502	RADIOLOGY-DIAGNOSTIC	54.00	0	33.16
33.17	EKG DEPARTMENT PROGRAM REVENUE	B	-2,000	ELECTROCARDIOLOGY	69.00	0	33.17
33.18	IRF PHO REVENUE	B	-4,715	SUBPROVIDER - IRF	41.00	0	33.18
33.19	LOSS ON 1991 BONDS	A	60,932	CAP REL COSTS-BLDG & FIXT	1.00	9	33.19
33.20	LOSS ON 1991 BONDS	A	83,594	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.20
33.21	CABLE TV	A	-959	CLINIC	90.00	0	33.21
33.22	REAL ESTATE TAXES	A	-175,403	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.22
33.23	MISCELLANEOUS INCOME	B	183	CARDIAC REHABILITATION	76.97	0	33.23
33.24	REAL ESTATE TAXES	A	-9,568	PHYSICAL THERAPY	66.00	0	33.24
33.25	CABLE TV	A	-605	PHYSICAL THERAPY	66.00	0	33.25
33.26	MISCELLANEOUS INCOME	B	-125	PHYSICAL THERAPY	66.00	0	33.26
33.27	ALCOHOL PURCHASE	A	-19	OPERATING ROOM	50.00	0	33.27
33.28	ALCOHOL PURCHASE	A	-29	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.28
33.29	ALCOHOL PURCHASE	A	-57	ELECTROCARDIOLOGY	69.00	0	33.29
33.30	ALCOHOL PURCHASE	A	-24	MEDICAL RECORDS & LIBRARY	16.00	0	33.30
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,631,338				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: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-8-1

Date/Time Prepared:
8/16/2019 10:56 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	329,334	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	2,762,334	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	4,439,901	0	3.00
4.00	5.01	DATA PROCESSING	HOME OFFICE	6,731,375	0	4.00
4.01	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	2,361,014	0	4.01
4.02	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	7,324,981	0	4.02
4.03	60.00	LABORATORY	RENT	34,281	71,214	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	RENT	49,249	111,490	4.04
4.05	66.00	PHYSICAL THERAPY	RENT	71,149	162,756	4.05
4.06	69.00	ELECTROCARDIOLOGY	RENT	70,513	141,096	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			24,174,131	486,556	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
	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	SIHS	100.00	RELATED ORG	100.00	6.00
7.00	B	SIHE	100.00	RELATED ORG	100.00	7.00
8.00	B	HSSI	100.00	RELATED ORG	100.00	8.00
9.00	B	SIMS	100.00	RELATED ORG	100.00	9.00
10.00	B	SIH CAYMAN	100.00	RELATED ORG	100.00	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: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-8-1

Date/Time Prepared:
8/16/2019 10:56 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	329,334	9		1.00
2.00	2,762,334	9		2.00
3.00	4,439,901	0		3.00
4.00	6,731,375	0		4.00
4.01	2,361,014	0		4.01
4.02	7,324,981	0		4.02
4.03	-36,933	0		4.03
4.04	-62,241	0		4.04
4.05	-91,607	0		4.05
4.06	-70,583	0		4.06
5.00	23,687,575			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	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
10.00	CAPTIVE		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: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-8-2

Date/Time Prepared:
8/16/2019 10:56 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	DR. A	253,704	253,704	0	0	0	1.00
2.00	65.00	DR. B	37,238	0	37,238	179,000	217	2.00
3.00	69.00	DR. C	63,368	63,368	0	0	0	3.00
4.00	76.97	DR. D	1,640	200	1,440	179,000	9	4.00
5.00	91.00	DR. E	5,218,995	5,201,952	17,043	181,300	124	5.00
6.00	30.00	DR. F	3,002,697	3,002,697	0	0	0	6.00
7.00	41.00	DR. G	1,410,658	1,410,658	0	0	0	7.00
8.00	50.00	DR. H	55,511	12,981	42,530	246,400	253	8.00
9.00	30.00	DR. I	9,800	4,900	4,900	179,000	14	9.00
10.00	90.00	DR. J	11,002	11,002	0	0	0	10.00
11.00	5.04	DR. K	22,358	22,358	0	0	0	11.00
200.00			10,086,971	9,983,820	103,151		617	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	60.00	DR. A	0	0	0	0	0	1.00
2.00	65.00	DR. B	18,675	934	0	0	0	2.00
3.00	69.00	DR. C	0	0	0	0	0	3.00
4.00	76.97	DR. D	775	39	0	0	0	4.00
5.00	91.00	DR. E	10,808	540	0	0	0	5.00
6.00	30.00	DR. F	0	0	0	0	0	6.00
7.00	41.00	DR. G	0	0	0	0	0	7.00
8.00	50.00	DR. H	29,971	1,499	0	0	0	8.00
9.00	30.00	DR. I	1,205	60	0	0	0	9.00
10.00	90.00	DR. J	0	0	0	0	0	10.00
11.00	5.04	DR. K	0	0	0	0	0	11.00
200.00			61,434	3,072	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	60.00	DR. A	0	0	0	253,704		1.00
2.00	65.00	DR. B	0	18,675	18,563	18,563		2.00
3.00	69.00	DR. C	0	0	0	63,368		3.00
4.00	76.97	DR. D	0	775	665	865		4.00
5.00	91.00	DR. E	0	10,808	6,235	5,208,187		5.00
6.00	30.00	DR. F	0	0	0	3,002,697		6.00
7.00	41.00	DR. G	0	0	0	1,410,658		7.00
8.00	50.00	DR. H	0	29,971	12,559	25,540		8.00
9.00	30.00	DR. I	0	1,205	3,695	8,595		9.00
10.00	90.00	DR. J	0	0	0	11,002		10.00
11.00	5.04	DR. K	0	0	0	22,358		11.00
200.00			0	61,434	41,717	10,025,537		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,522,519	5,522,519			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	6,258,548		6,258,548		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,723,922	40,094	5,020	13,769,036	4.00
5.01	00550	DATA PROCESSING	6,731,375	25,476	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	298,922	45,524	293	64,657	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,490,404	44,443	7,477	321,933	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	12,042,259	1,013,625	47,772	1,104,300	5.04
6.00	00600	MAINTENANCE & REPAIRS	1,855,860	686,120	11,244	172,741	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	515,661	0	630	12,893	8.00
9.00	00900	HOUSEKEEPING	1,576,520	75,791	27,126	368,695	9.00
10.00	01000	DIETARY	654,038	85,249	24,469	109,687	10.00
11.00	01100	CAFETERIA	702,435	101,832	0	217,159	11.00
13.00	01300	NURSING ADMINISTRATION	1,069,305	27,147	420,564	282,792	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	268,167	57,046	0	61,975	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	322,313	0	0	107,726	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,940,691	927,692	319,128	2,416,459	30.00
31.00	03100	INTENSIVE CARE UNIT	2,084,697	108,490	191,367	487,717	31.00
41.00	04100	SUBPROVIDER - IRF	3,569,667	424,329	115,769	987,028	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,321,390	670,299	2,732,581	1,242,288	50.00
51.00	05100	RECOVERY ROOM	725,480	103,208	9,094	201,499	51.00
53.00	05300	ANESTHESIOLOGY	696,956	688	62,670	131,147	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,893,812	167,747	699,276	636,633	54.00
56.00	05600	RADIOISOTOPE	1,371,529	35,279	5,606	75,031	56.00
57.00	05700	CT SCAN	811,905	25,059	370,570	130,965	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	733,663	17,959	316,201	104,002	58.00
60.00	06000	LABORATORY	6,568,763	142,295	302,710	598,974	60.00
65.00	06500	RESPIRATORY THERAPY	1,357,730	77,535	93,246	356,637	65.00
66.00	06600	PHYSICAL THERAPY	6,812,013	191,577	58,404	1,594,410	66.00
69.00	06900	ELECTROCARDIOLOGY	1,325,547	66,406	136,351	306,177	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,400,965	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,107,938	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,103,281	46,654	75,201	615,675	73.00
76.97	07697	CARDIAC REHABILITATION	438,562	46,138	18,356	123,102	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	468,615	0	28,951	49,100	90.00
91.00	09100	EMERGENCY	4,388,336	247,689	167,263	887,634	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,153,788	5,501,391	6,247,339	13,769,036	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,128	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	229,591	0	11,209	0	192.00
192.01	19201	VACANT SPACE	0	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	192.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	128,383,379	5,522,519	6,258,548	13,769,036	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
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	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	460,254					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,874	4,091,359				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	14,643,882	14,643,882		5.04
6.00	00600	MAINTENANCE & REPAIRS	6	0	2,864,014	368,739	3,232,753	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	536,449	69,067	0	8.00
9.00	00900	HOUSEKEEPING	6	0	2,069,934	266,502	66,811	9.00
10.00	01000	DIETARY	0	0	946,097	121,809	75,149	10.00
11.00	01100	CAFETERIA	0	0	1,021,426	131,508	89,767	11.00
13.00	01300	NURSING ADMINISTRATION	40	0	1,828,910	235,470	23,931	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,404	0	395,857	50,966	50,287	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	582,613	75,011	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	100,785	155,987	15,972,355	2,056,462	817,784	30.00
31.00	03100	INTENSIVE CARE UNIT	24,694	20,933	3,048,676	392,514	95,636	31.00
41.00	04100	SUBPROVIDER - IRF	13,794	85,413	5,820,827	749,426	374,056	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	186,776	683,826	15,810,728	2,035,615	590,884	50.00
51.00	05100	RECOVERY ROOM	149	55,799	1,189,680	153,170	90,980	51.00
53.00	05300	ANESTHESIOLOGY	8,723	105,453	1,078,291	138,829	606	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,170	234,065	4,923,055	633,838	147,873	54.00
56.00	05600	RADIOISOTOPE	800	138,108	1,677,211	215,939	31,099	56.00
57.00	05700	CT SCAN	10,178	526,111	1,896,584	244,183	22,090	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	827	162,615	1,357,063	174,721	15,831	58.00
60.00	06000	LABORATORY	20,331	637,973	8,641,583	1,112,595	125,436	60.00
65.00	06500	RESPIRATORY THERAPY	6,941	58,730	2,132,455	274,551	68,349	65.00
66.00	06600	PHYSICAL THERAPY	1,964	257,653	9,758,811	1,256,437	168,880	66.00
69.00	06900	ELECTROCARDIOLOGY	2,500	194,088	2,292,625	295,173	58,538	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	139,762	3,540,727	455,865	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	132,289	7,240,227	932,172	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	791	199,188	9,164,302	1,179,895	41,126	73.00
76.97	07697	CARDIAC REHABILITATION	126	15,930	729,399	93,909	40,671	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,590	22,848	643,758	82,883	0	90.00
91.00	09100	EMERGENCY	67,785	264,588	6,313,912	812,910	218,344	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	460,254	4,091,359	128,121,451	14,610,159	3,214,128	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	21,128	2,720	18,625	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	240,800	31,003	0	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
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)	460,254	4,091,359	128,383,379	14,643,882	3,232,753	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
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	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	605,516					8.00
9.00	00900	HOUSEKEEPING	0	2,403,247				9.00
10.00	01000	DIETARY	0	57,045	1,200,100			10.00
11.00	01100	CAFETERIA	0	68,142	0	1,310,843		11.00
13.00	01300	NURSING ADMINISTRATION	0	18,166	0	32,526	2,139,003	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	38,173	0	7,128	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	12,390	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	407,452	620,774	807,548	277,923	893,657	30.00
31.00	03100	INTENSIVE CARE UNIT	47,147	72,597	93,443	56,096	143,073	31.00
41.00	04100	SUBPROVIDER - IRF	150,917	283,944	299,109	113,526	371,931	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	448,536	0	142,886	354,606	50.00
51.00	05100	RECOVERY ROOM	0	69,063	0	23,176	53,105	51.00
53.00	05300	ANESTHESIOLOGY	0	460	0	15,084	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	112,249	0	73,224	0	54.00
56.00	05600	RADIOISOTOPE	0	23,607	0	8,630	0	56.00
57.00	05700	CT SCAN	0	16,768	0	15,063	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12,017	0	11,962	0	58.00
60.00	06000	LABORATORY	0	95,218	0	68,893	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	51,883	0	41,020	0	65.00
66.00	06600	PHYSICAL THERAPY	0	128,196	0	183,386	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	44,436	0	35,216	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	31,219	0	70,814	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	30,873	0	14,159	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,647	0	90.00
91.00	09100	EMERGENCY	0	165,743	0	102,094	322,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	605,516	2,389,109	1,200,100	1,310,843	2,139,003	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,138	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
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)	605,516	2,403,247	1,200,100	1,310,843	2,139,003	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	542,411					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	670,014				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,992	25,538	0	21,885,485	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,581	3,427	0	3,954,190	0	31.00
41.00	04100	SUBPROVIDER - IRF	251	13,984	0	8,177,971	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	427,345	112,128	0	19,922,728	0	50.00
51.00	05100	RECOVERY ROOM	0	9,136	0	1,588,310	0	51.00
53.00	05300	ANESTHESIOLOGY	5,562	17,265	0	1,256,097	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,719	38,321	0	5,939,279	0	54.00
56.00	05600	RADIOISOTOPE	0	22,611	0	1,979,097	0	56.00
57.00	05700	CT SCAN	1,745	86,136	0	2,282,569	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	26,624	0	1,598,218	0	58.00
60.00	06000	LABORATORY	69,193	104,450	0	10,217,368	0	60.00
65.00	06500	RESPIRATORY THERAPY	10,801	9,615	0	2,588,674	0	65.00
66.00	06600	PHYSICAL THERAPY	0	42,183	0	11,537,893	0	66.00
69.00	06900	ELECTROCARDIOLOGY	725	31,776	0	2,758,489	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	115	22,882	0	4,019,589	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,659	0	8,194,058	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83	32,611	0	10,520,050	0	73.00
76.97	07697	CARDIAC REHABILITATION	7	2,608	0	911,626	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,002	3,741	0	740,031	0	90.00
91.00	09100	EMERGENCY	4,290	43,319	0	7,983,243	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	542,411	670,014	0	128,054,965	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	56,611	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	271,803	0	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
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)	542,411	670,014	0	128,383,379	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00550	DATA PROCESSING	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	5.04
6.00	00600	MAINTENANCE & REPAIRS	6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	VACANT SPACE	192.01
192.02	19202	REFERENCE LAB	192.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0011

Period:

From 04/01/2018

To 03/31/2019

Worksheet Non-CMS W

Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.01	DATA PROCESSING	5	NUMBER OF PCS	5.01
5.02	PURCHASING RECEIVING AND STORES	6	PURCHASING SUPPLIES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	7	GROSS REVENUE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	8	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	9	MEALS SERVED	10.00
11.00	CAFETERIA	4	GROSS SALARIES	11.00
13.00	NURSING ADMINISTRATION	10	NURSING SALARIES	13.00
14.00	CENTRAL SERVICES & SUPPLY	11	COSTED REQUIS.	14.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
19.00	NONPHYSICIAN ANESTHETISTS	19	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	40,094	5,020	45,114	4.00
5.01	00550	DATA PROCESSING	0	25,476	0	25,476	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	45,524	293	45,817	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	44,443	7,477	51,920	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	1,013,625	47,772	1,061,397	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	686,120	11,244	697,364	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	630	630	8.00
9.00	00900	HOUSEKEEPING	0	75,791	27,126	102,917	9.00
10.00	01000	DIETARY	0	85,249	24,469	109,718	10.00
11.00	01100	CAFETERIA	0	101,832	0	101,832	11.00
13.00	01300	NURSING ADMINISTRATION	0	27,147	420,564	447,711	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	57,046	0	57,046	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	927,692	319,128	1,246,820	30.00
31.00	03100	INTENSIVE CARE UNIT	0	108,490	191,367	299,857	31.00
41.00	04100	SUBPROVIDER - IRF	0	424,329	115,769	540,098	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	670,299	2,732,581	3,402,880	50.00
51.00	05100	RECOVERY ROOM	0	103,208	9,094	112,302	51.00
53.00	05300	ANESTHESIOLOGY	0	688	62,670	63,358	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	167,747	699,276	867,023	54.00
56.00	05600	RADIOISOTOPE	0	35,279	5,606	40,885	56.00
57.00	05700	CT SCAN	0	25,059	370,570	395,629	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	17,959	316,201	334,160	58.00
60.00	06000	LABORATORY	0	142,295	302,710	445,005	60.00
65.00	06500	RESPIRATORY THERAPY	0	77,535	93,246	170,781	65.00
66.00	06600	PHYSICAL THERAPY	0	191,577	58,404	249,981	66.00
69.00	06900	ELECTROCARDIOLOGY	0	66,406	136,351	202,757	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	46,654	75,201	121,855	73.00
76.97	07697	CARDIAC REHABILITATION	0	46,138	18,356	64,494	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	28,951	28,951	90.00
91.00	09100	EMERGENCY	0	247,689	167,263	414,952	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,501,391	6,247,339	11,748,730	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,128	0	21,128	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	11,209	11,209	192.00
192.01	19201	VACANT SPACE	0	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	192.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,522,519	6,258,548	11,781,067	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
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	00550	DATA PROCESSING	25,476					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	192	46,221				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	849	188	54,012			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,644	0	0	1,066,661		5.04
6.00	00600	MAINTENANCE & REPAIRS	520	1	0	26,859	725,310	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	27	0	0	5,031	0	8.00
9.00	00900	HOUSEKEEPING	82	1	0	19,412	14,990	9.00
10.00	01000	DIETARY	274	0	0	8,872	16,861	10.00
11.00	01100	CAFETERIA	0	0	0	9,579	20,140	11.00
13.00	01300	NURSING ADMINISTRATION	110	4	0	17,152	5,369	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27	141	0	3,712	11,283	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	575	0	0	5,464	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,191	10,122	2,055	149,801	183,482	30.00
31.00	03100	INTENSIVE CARE UNIT	493	2,480	276	28,590	21,457	31.00
41.00	04100	SUBPROVIDER - IRF	2,356	1,385	1,125	54,588	83,924	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,671	18,755	9,129	148,273	132,572	50.00
51.00	05100	RECOVERY ROOM	356	15	735	11,157	20,413	51.00
53.00	05300	ANESTHESIOLOGY	274	876	1,389	10,112	136	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,068	821	3,083	46,168	33,177	54.00
56.00	05600	RADIOISOTOPE	192	80	1,819	15,729	6,977	56.00
57.00	05700	CT SCAN	82	1,022	6,929	17,786	4,956	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	82	83	2,142	12,727	3,552	58.00
60.00	06000	LABORATORY	1,397	2,042	8,403	81,041	28,143	60.00
65.00	06500	RESPIRATORY THERAPY	685	697	774	19,998	15,335	65.00
66.00	06600	PHYSICAL THERAPY	3,178	197	3,394	91,518	37,890	66.00
69.00	06900	ELECTROCARDIOLOGY	986	251	2,556	21,500	13,134	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,841	33,205	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,742	67,899	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	466	79	2,624	85,943	9,227	73.00
76.97	07697	CARDIAC REHABILITATION	329	13	210	6,840	9,125	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	274	160	301	6,037	0	90.00
91.00	09100	EMERGENCY	1,096	6,808	3,485	59,212	48,988	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,476	46,221	54,012	1,064,205	721,131	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	198	4,179	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	2,258	0	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
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)	25,476	46,221	54,012	1,066,661	725,310	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
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	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,730					8.00
9.00	00900	HOUSEKEEPING	0	138,611				9.00
10.00	01000	DIETARY	0	3,290	139,375			10.00
11.00	01100	CAFETERIA	0	3,930	0	136,193		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,048	0	3,380	475,701	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,202	0	741	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,287	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,856	35,803	93,786	28,868	198,744	30.00
31.00	03100	INTENSIVE CARE UNIT	446	4,187	10,852	5,829	31,819	31.00
41.00	04100	SUBPROVIDER - IRF	1,428	16,377	34,737	11,796	82,715	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	25,870	0	14,846	78,862	50.00
51.00	05100	RECOVERY ROOM	0	3,983	0	2,408	11,810	51.00
53.00	05300	ANESTHESIOLOGY	0	27	0	1,567	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,474	0	7,608	0	54.00
56.00	05600	RADIOISOTOPE	0	1,362	0	897	0	56.00
57.00	05700	CT SCAN	0	967	0	1,565	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	693	0	1,243	0	58.00
60.00	06000	LABORATORY	0	5,492	0	7,158	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,992	0	4,262	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,394	0	19,055	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,563	0	3,659	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,801	0	7,358	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,781	0	1,471	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	587	0	90.00
91.00	09100	EMERGENCY	0	9,560	0	10,608	71,751	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,730	137,796	139,375	136,193	475,701	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	815	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
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)	5,730	138,611	139,375	136,193	475,701	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	75,355					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,679				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	832	286		1,966,543	0	30.00
31.00	03100	INTENSIVE CARE UNIT	220	38		408,143	0	31.00
41.00	04100	SUBPROVIDER - IRF	35	157		833,957	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	59,371	1,431		3,899,732	0	50.00
51.00	05100	RECOVERY ROOM	0	102		163,942	0	51.00
53.00	05300	ANESTHESIOLOGY	773	193		79,135	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,489	429		969,427	0	54.00
56.00	05600	RADIOISOTOPE	0	253		68,440	0	56.00
57.00	05700	CT SCAN	242	965		430,572	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	298		355,321	0	58.00
60.00	06000	LABORATORY	9,612	1,170		591,427	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,500	108		218,301	0	65.00
66.00	06600	PHYSICAL THERAPY	0	473		418,307	0	66.00
69.00	06900	ELECTROCARDIOLOGY	101	356		248,867	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16	256		35,318	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	243		69,884	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11	365		231,747	0	73.00
76.97	07697	CARDIAC REHABILITATION	1	29		84,697	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	556	42		37,069	0	90.00
91.00	09100	EMERGENCY	596	485		630,451	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,355	7,679	0	11,741,280	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		26,320	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		13,467	0	192.00
192.01	19201	VACANT SPACE	0	0		0	0	192.01
192.02	19202	REFERENCE LAB	0	0		0	0	192.02
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	75,355	7,679	0	11,781,067	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00550	DATA PROCESSING	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	5.04
6.00	00600	MAINTENANCE & REPAIRS	6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	VACANT SPACE	192.01
192.02	19202	REFERENCE LAB	192.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-1

Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (NUMBER OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASING SUPPLIES)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	224,790				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,138,056			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,632	2,517	46,628,497		4.00
5.01	00550	DATA PROCESSING	1,037	0	0	930	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	1,853	147	218,958	7	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,809	3,749	1,090,219	31	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	41,259	23,953	3,739,687	60	5.04
6.00	00600	MAINTENANCE & REPAIRS	27,928	5,638	584,985	19	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	316	43,662	1	8.00
9.00	00900	HOUSEKEEPING	3,085	13,601	1,248,577	3	9.00
10.00	01000	DIETARY	3,470	12,269	371,451	10	10.00
11.00	01100	CAFETERIA	4,145	0	735,404	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,105	210,872	957,670	4	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,322	0	209,876	1	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	364,812	21	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	37,761	160,012	8,183,245	153	30.00
31.00	03100	INTENSIVE CARE UNIT	4,416	95,952	1,651,644	18	31.00
41.00	04100	SUBPROVIDER - IRF	17,272	58,047	3,342,550	86	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	27,284	1,370,124	4,206,981	134	50.00
51.00	05100	RECOVERY ROOM	4,201	4,560	682,372	13	51.00
53.00	05300	ANESTHESIOLOGY	28	31,423	444,128	10	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,828	350,619	2,155,944	39	54.00
56.00	05600	RADIOISOTOPE	1,436	2,811	254,090	7	56.00
57.00	05700	CT SCAN	1,020	185,805	443,509	3	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	731	158,544	352,199	3	58.00
60.00	06000	LABORATORY	5,792	151,780	2,028,414	51	60.00
65.00	06500	RESPIRATORY THERAPY	3,156	46,754	1,207,743	25	65.00
66.00	06600	PHYSICAL THERAPY	7,798	29,284	5,399,434	116	66.00
69.00	06900	ELECTROCARDIOLOGY	2,703	68,367	1,036,861	36	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,899	37,706	2,084,970	17	73.00
76.97	07697	CARDIAC REHABILITATION	1,878	9,204	416,883	12	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	14,516	166,276	10	90.00
91.00	09100	EMERGENCY	10,082	83,866	3,005,953	40	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	223,930	3,132,436	46,628,497	930	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	860	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,620	0	0	192.00
192.01	19201	VACANT SPACE	0	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	192.02
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)	5,522,519	6,258,548	13,769,036	6,756,851	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.567459	1.994403	0.295292	7,265.431183	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			45,114	25,476	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000968	27.393548	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: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-1

Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
			5.03	5A.04	5.04	6.00	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	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	682,176,911					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	-14,643,882	113,739,497			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	2,864,014	149,272		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	536,449	0	28,499	8.00
9.00	00900	HOUSEKEEPING	0	0	2,069,934	3,085	0	9.00
10.00	01000	DIETARY	0	0	946,097	3,470	0	10.00
11.00	01100	CAFETERIA	0	0	1,021,426	4,145	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,828,910	1,105	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	395,857	2,322	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	582,613	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,006,529	0	15,972,355	37,761	19,177	30.00
31.00	03100	INTENSIVE CARE UNIT	3,489,981	0	3,048,676	4,416	2,219	31.00
41.00	04100	SUBPROVIDER - IRF	14,240,289	0	5,820,827	17,272	7,103	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	114,065,153	0	15,810,728	27,284	0	50.00
51.00	05100	RECOVERY ROOM	9,303,014	0	1,189,680	4,201	0	51.00
53.00	05300	ANESTHESIOLOGY	17,581,332	0	1,078,291	28	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,023,799	0	4,923,055	6,828	0	54.00
56.00	05600	RADIOISOTOPE	23,025,620	0	1,677,211	1,436	0	56.00
57.00	05700	CT SCAN	87,714,463	0	1,896,584	1,020	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	27,111,589	0	1,357,063	731	0	58.00
60.00	06000	LABORATORY	106,364,359	0	8,641,583	5,792	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,791,668	0	2,132,455	3,156	0	65.00
66.00	06600	PHYSICAL THERAPY	42,956,534	0	9,758,811	7,798	0	66.00
69.00	06900	ELECTROCARDIOLOGY	32,358,802	0	2,292,625	2,703	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,301,468	0	3,540,727	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,055,544	0	7,240,227	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,209,037	0	9,164,302	1,899	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,655,854	0	729,399	1,878	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,809,202	0	643,758	0	0	90.00
91.00	09100	EMERGENCY	44,112,674	0	6,313,912	10,082	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	682,176,911	-14,643,882	113,477,569	148,412	28,499	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	21,128	860	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	240,800	0	0	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
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)	4,091,359		14,643,882	3,232,753	605,516	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005998		0.128749	21.656794	21.246921	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	54,012		1,066,661	725,310	5,730	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000079		0.009378	4.858982	0.201060	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: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-1

Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			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	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	146,187					9.00
10.00	01000	DIETARY	3,470	85,497				10.00
11.00	01100	CAFETERIA	4,145	0	38,595,554			11.00
13.00	01300	NURSING ADMINISTRATION	1,105	0	957,670	729,685		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,322	0	209,876	0	3,853,402	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	364,812	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	37,761	57,531	8,183,245	304,856	42,566	30.00
31.00	03100	INTENSIVE CARE UNIT	4,416	6,657	1,651,644	48,807	11,234	31.00
41.00	04100	SUBPROVIDER - IRF	17,272	21,309	3,342,550	126,878	1,781	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,284	0	4,206,981	120,968	3,035,949	50.00
51.00	05100	RECOVERY ROOM	4,201	0	682,372	18,116	0	51.00
53.00	05300	ANESTHESIOLOGY	28	0	444,128	0	39,517	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,828	0	2,155,944	0	76,151	54.00
56.00	05600	RADIOISOTOPE	1,436	0	254,090	0	0	56.00
57.00	05700	CT SCAN	1,020	0	443,509	0	12,396	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	731	0	352,199	0	0	58.00
60.00	06000	LABORATORY	5,792	0	2,028,414	0	491,562	60.00
65.00	06500	RESPIRATORY THERAPY	3,156	0	1,207,743	0	76,731	65.00
66.00	06600	PHYSICAL THERAPY	7,798	0	5,399,434	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,703	0	1,036,861	0	5,151	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	814	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,899	0	2,084,970	0	588	73.00
76.97	07697	CARDIAC REHABILITATION	1,878	0	416,883	0	50	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	166,276	0	28,432	90.00
91.00	09100	EMERGENCY	10,082	0	3,005,953	110,060	30,480	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,327	85,497	38,595,554	729,685	3,853,402	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	860	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
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)	2,403,247	1,200,100	1,310,843	2,139,003	542,411	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.439540	14.036750	0.033964	2.931406	0.140762	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	138,611	139,375	136,193	475,701	75,355	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.948176	1.630174	0.003529	0.651927	0.019555	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: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-1

Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			16.00	19.00	
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	00550	DATA PROCESSING			5.01
5.02	00560	PURCHASING RECEIVING AND STORES			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL			5.04
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY	682,176,911		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	26,006,529	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,489,981	0	31.00
41.00	04100	SUBPROVIDER - IRF	14,240,289	0	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	114,065,153	0	50.00
51.00	05100	RECOVERY ROOM	9,303,014	0	51.00
53.00	05300	ANESTHESIOLOGY	17,581,332	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,023,799	0	54.00
56.00	05600	RADIOISOTOPE	23,025,620	0	56.00
57.00	05700	CT SCAN	87,714,463	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	27,111,589	0	58.00
60.00	06000	LABORATORY	106,364,359	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,791,668	0	65.00
66.00	06600	PHYSICAL THERAPY	42,956,534	0	66.00
69.00	06900	ELECTROCARDIOLOGY	32,358,802	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,301,468	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,055,544	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,209,037	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,655,854	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3,809,202	0	90.00
91.00	09100	EMERGENCY	44,112,674	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	682,176,911	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	VACANT SPACE	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	192.02
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)	670,014	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000982	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,679	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000011	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/16/2019 10:56 am

			Title XVIII		Hospital	PPS		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	21,885,485		21,885,485	3,695	21,889,180	30.00
31.00	03100	INTENSIVE CARE UNIT	3,954,190		3,954,190	0	3,954,190	31.00
41.00	04100	SUBPROVIDER - IRF	8,177,971		8,177,971	0	8,177,971	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,922,728		19,922,728	12,559	19,935,287	50.00
51.00	05100	RECOVERY ROOM	1,588,310		1,588,310	0	1,588,310	51.00
53.00	05300	ANESTHESIOLOGY	1,256,097		1,256,097	0	1,256,097	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,939,279		5,939,279	0	5,939,279	54.00
56.00	05600	RADIOISOTOPE	1,979,097		1,979,097	0	1,979,097	56.00
57.00	05700	CT SCAN	2,282,569		2,282,569	0	2,282,569	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,598,218		1,598,218	0	1,598,218	58.00
60.00	06000	LABORATORY	10,217,368		10,217,368	0	10,217,368	60.00
65.00	06500	RESPIRATORY THERAPY	2,588,674	0	2,588,674	18,563	2,607,237	65.00
66.00	06600	PHYSICAL THERAPY	11,537,893	0	11,537,893	0	11,537,893	66.00
69.00	06900	ELECTROCARDIOLOGY	2,758,489		2,758,489	0	2,758,489	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,019,589		4,019,589	0	4,019,589	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,194,058		8,194,058	0	8,194,058	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,520,050		10,520,050	0	10,520,050	73.00
76.97	07697	CARDIAC REHABILITATION	911,626		911,626	665	912,291	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	740,031		740,031	0	740,031	90.00
91.00	09100	EMERGENCY	7,983,243		7,983,243	6,235	7,989,478	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,124,190		2,124,190		2,124,190	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	130,179,155	0	130,179,155	41,717	130,220,872	200.00
201.00		Less Observation Beds	2,124,190		2,124,190		2,124,190	201.00
202.00		Total (see instructions)	128,054,965	0	128,054,965	41,717	128,096,682	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/16/2019 10:56 am

			Title XVIII		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,531,340		21,531,340			30.00
31.00	03100	INTENSIVE CARE UNIT	3,489,981		3,489,981			31.00
41.00	04100	SUBPROVIDER - IRF	12,766,992		12,766,992			41.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	39,331,365	72,426,800	111,758,165	0.178266	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,086,413	4,601,959	8,688,372	0.182809	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	6,061,375	11,077,319	17,138,694	0.073290	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,197,989	32,029,754	38,227,743	0.155366	0.000000	54.00
56.00	05600	RADIOISOTOPE	2,902,778	19,845,756	22,748,534	0.086999	0.000000	56.00
57.00	05700	CT SCAN	23,053,617	63,606,263	86,659,880	0.026339	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,377,640	22,151,302	26,528,942	0.060244	0.000000	58.00
60.00	06000	LABORATORY	26,119,938	78,351,423	104,471,361	0.097801	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,201,389	2,564,370	9,765,759	0.265077	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	13,873,288	28,131,945	42,005,233	0.274678	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	10,958,342	21,155,441	32,113,783	0.085897	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,852,621	10,164,658	23,017,279	0.174634	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,057,279	7,885,100	21,942,379	0.373435	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,873,154	9,051,856	32,925,010	0.319515	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	2,250	2,624,305	2,626,555	0.347080	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	112,046	3,546,591	3,658,637	0.202270	0.000000	90.00
91.00	09100	EMERGENCY	10,756,944	32,806,423	43,563,367	0.183256	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	539,899	3,884,141	4,424,040	0.480147	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	244,146,640	425,905,406	670,052,046			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	244,146,640	425,905,406	670,052,046			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0011	Period: From 04/01/2018 To 03/31/2019	Worksheet C Part I Date/Time Prepared: 8/16/2019 10:56 am
				Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio			
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		30.00		
31.00	03100	INTENSIVE CARE UNIT		31.00		
41.00	04100	SUBPROVIDER - IRF		41.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.178379	50.00		
51.00	05100	RECOVERY ROOM	0.182809	51.00		
53.00	05300	ANESTHESIOLOGY	0.073290	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155366	54.00		
56.00	05600	RADIOISOTOPE	0.086999	56.00		
57.00	05700	CT SCAN	0.026339	57.00		
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.060244	58.00		
60.00	06000	LABORATORY	0.097801	60.00		
65.00	06500	RESPIRATORY THERAPY	0.266977	65.00		
66.00	06600	PHYSICAL THERAPY	0.274678	66.00		
69.00	06900	ELECTROCARDIOLOGY	0.085897	69.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.174634	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.373435	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319515	73.00		
76.97	07697	CARDIAC REHABILITATION	0.347334	76.97		
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.202270	90.00		
91.00	09100	EMERGENCY	0.183399	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.480147	92.00		
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		113.00		
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: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/16/2019 10:56 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,885,485		21,885,485	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,954,190		3,954,190	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	8,177,971		8,177,971	0	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,922,728		19,922,728	0	0	50.00
51.00	05100	RECOVERY ROOM	1,588,310		1,588,310	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,256,097		1,256,097	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,939,279		5,939,279	0	0	54.00
56.00	05600	RADIOISOTOPE	1,979,097		1,979,097	0	0	56.00
57.00	05700	CT SCAN	2,282,569		2,282,569	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,598,218		1,598,218	0	0	58.00
60.00	06000	LABORATORY	10,217,368		10,217,368	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,588,674	0	2,588,674	0	0	65.00
66.00	06600	PHYSICAL THERAPY	11,537,893	0	11,537,893	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,758,489		2,758,489	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,019,589		4,019,589	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,194,058		8,194,058	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,520,050		10,520,050	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	911,626		911,626	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	740,031		740,031	0	0	90.00
91.00	09100	EMERGENCY	7,983,243		7,983,243	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	128,054,965	0	128,054,965	0	0	200.00
201.00		Less Observation Beds	0		0			201.00
202.00		Total (see instructions)	128,054,965	0	128,054,965	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/16/2019 10:56 am

			Title XIX		Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0011	Period: From 04/01/2018 To 03/31/2019	Worksheet C Part I Date/Time Prepared: 8/16/2019 10:56 am
				Title XIX	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio			
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part I
Date/Time Prepared:
8/16/2019 10:56 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,966,543	0	1,966,543	21,238	92.60	30.00
31.00	INTENSIVE CARE UNIT	408,143		408,143	2,219	183.93	31.00
41.00	SUBPROVIDER - IRF	833,957	0	833,957	7,103	117.41	41.00
200.00	Total (lines 30 through 199)	3,208,643		3,208,643	30,560		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	11,360	1,051,936				30.00
31.00	INTENSIVE CARE UNIT	1,366	251,248				31.00
41.00	SUBPROVIDER - IRF	4,802	563,803				41.00
200.00	Total (lines 30 through 199)	17,528	1,866,987				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part II
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,899,732	111,758,165	0.034894	18,221,361	635,816
51.00	05100	RECOVERY ROOM	163,942	8,688,372	0.018869	1,806,509	34,087
53.00	05300	ANESTHESIOLOGY	79,135	17,138,694	0.004617	2,687,969	12,410
54.00	05400	RADIOLOGY-DIAGNOSTIC	969,427	38,227,743	0.025359	2,581,180	65,456
56.00	05600	RADIOISOTOPE	68,440	22,748,534	0.003009	1,738,182	5,230
57.00	05700	CT SCAN	430,572	86,659,880	0.004969	11,728,883	58,281
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	355,321	26,528,942	0.013394	2,025,289	27,127
60.00	06000	LABORATORY	591,427	104,471,361	0.005661	14,757,583	83,543
65.00	06500	RESPIRATORY THERAPY	218,301	9,765,759	0.022354	4,319,738	96,563
66.00	06600	PHYSICAL THERAPY	418,307	42,005,233	0.009958	3,005,421	29,928
69.00	06900	ELECTROCARDIOLOGY	248,867	32,113,783	0.007750	5,870,226	45,494
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,318	23,017,279	0.001534	4,620,504	7,088
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,884	21,942,379	0.003185	7,383,852	23,518
73.00	07300	DRUGS CHARGED TO PATIENTS	231,747	32,925,010	0.007039	13,290,494	93,552
76.97	07697	CARDIAC REHABILITATION	84,697	2,626,555	0.032246	1,694	55
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	37,069	3,658,637	0.010132	108,818	1,103
91.00	09100	EMERGENCY	630,451	43,563,367	0.014472	5,858,775	84,788
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	190,839	4,424,040	0.043137	412,538	17,796
200.00		Total (lines 50 through 199)	8,723,476	632,263,733		100,419,016	1,321,835

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0011		Period: From 04/01/2018 To 03/31/2019		Worksheet D Part III Date/Time Prepared: 8/16/2019 10:56 am	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	0	0	41.00
200.00		Total (lines 30 through 199)		0	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	21,238	0.00	11,360	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	2,219	0.00	1,366	31.00	
41.00	04100	SUBPROVIDER - IRF		0	0	7,103	0.00	4,802	41.00	
200.00		Total (lines 30 through 199)		0	0	30,560		17,528	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
					9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0					30.00
31.00	03100	INTENSIVE CARE UNIT		0	0					31.00
41.00	04100	SUBPROVIDER - IRF		0	0					41.00
200.00		Total (lines 30 through 199)		0	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011		Period: From 04/01/2018 To 03/31/2019		Worksheet D Part IV Date/Time Prepared: 8/16/2019 10:56 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
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: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			Title XVIII		Hospital	PPS		
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	111,758,165	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	8,688,372	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	17,138,694	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,227,743	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	22,748,534	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	86,659,880	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	26,528,942	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	104,471,361	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,765,759	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	42,005,233	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	32,113,783	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	23,017,279	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,942,379	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	32,925,010	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,626,555	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	3,658,637	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	43,563,367	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,424,040	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	632,263,733		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			Title XVIII		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	18,221,361	0	23,389,496	0
51.00	05100	RECOVERY ROOM	0.000000	1,806,509	0	1,646,558	0
53.00	05300	ANESTHESIOLOGY	0.000000	2,687,969	0	3,521,749	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,581,180	0	8,763,150	0
56.00	05600	RADIOISOTOPE	0.000000	1,738,182	0	9,456,893	0
57.00	05700	CT SCAN	0.000000	11,728,883	0	23,281,331	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	2,025,289	0	7,699,922	0
60.00	06000	LABORATORY	0.000000	14,757,583	0	9,109,483	0
65.00	06500	RESPIRATORY THERAPY	0.000000	4,319,738	0	1,061,217	0
66.00	06600	PHYSICAL THERAPY	0.000000	3,005,421	0	169,871	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	5,870,226	0	8,130,571	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	4,620,504	0	3,086,008	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	7,383,852	0	3,101,348	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	13,290,494	0	4,566,166	0
76.97	07697	CARDIAC REHABILITATION	0.000000	1,694	0	1,120,952	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	108,818	0	1,980,123	0
91.00	09100	EMERGENCY	0.000000	5,858,775	0	9,006,813	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	412,538	0	1,697,316	0
200.00		Total (lines 50 through 199)		100,419,016	0	120,788,967	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011		Period: From 04/01/2018 To 03/31/2019	Worksheet D Part IV Date/Time Prepared: 8/16/2019 10:56 am
				Title XVIII		Hospital	PPS
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost			
			21.00	24.00			
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
56.00	05600	RADIOISOTOPE	0	0			56.00
57.00	05700	CT SCAN	0	0			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
60.00	06000	LABORATORY	0	0			60.00
65.00	06500	RESPIRATORY THERAPY	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			73.00
76.97	07697	CARDIAC REHABILITATION	0	0			76.97
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		Total (lines 50 through 199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part V
Date/Time Prepared:
8/16/2019 10:56 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.178266	23,389,496	0	0	4,169,552	50.00
51.00	05100	RECOVERY ROOM	0.182809	1,646,558	0	0	301,006	51.00
53.00	05300	ANESTHESIOLOGY	0.073290	3,521,749	0	0	258,109	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155366	8,763,150	0	0	1,361,496	54.00
56.00	05600	RADIOISOTOPE	0.086999	9,456,893	0	0	822,740	56.00
57.00	05700	CT SCAN	0.026339	23,281,331	0	0	613,207	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.060244	7,699,922	0	0	463,874	58.00
60.00	06000	LABORATORY	0.097801	9,109,483	0	0	890,917	60.00
65.00	06500	RESPIRATORY THERAPY	0.265077	1,061,217	0	0	281,304	65.00
66.00	06600	PHYSICAL THERAPY	0.274678	169,871	0	0	46,660	66.00
69.00	06900	ELECTROCARDIOLOGY	0.085897	8,130,571	0	0	698,392	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.174634	3,086,008	0	0	538,922	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.373435	3,101,348	0	0	1,158,152	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319515	4,566,166	0	37,815	1,458,959	73.00
76.97	07697	CARDIAC REHABILITATION	0.347080	1,120,952	0	0	389,060	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.202270	1,980,123	0	0	400,519	90.00
91.00	09100	EMERGENCY	0.183256	9,006,813	0	0	1,650,553	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.480147	1,697,316	0	0	814,961	92.00
200.00		Subtotal (see instructions)		120,788,967	0	37,815	16,318,383	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		120,788,967	0	37,815	16,318,383	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0011		Period: From 04/01/2018 To 03/31/2019		Worksheet D Part V Date/Time Prepared: 8/16/2019 10:56 am	
				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0			50.00		
51.00	05100	RECOVERY ROOM	0	0			51.00		
53.00	05300	ANESTHESIOLOGY	0	0			53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0			54.00		
56.00	05600	RADIOISOTOPE	0	0			56.00		
57.00	05700	CT SCAN	0	0			57.00		
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00		
60.00	06000	LABORATORY	0	0			60.00		
65.00	06500	RESPIRATORY THERAPY	0	0			65.00		
66.00	06600	PHYSICAL THERAPY	0	0			66.00		
69.00	06900	ELECTROCARDIOLOGY	0	0			69.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,082			73.00		
76.97	07697	CARDIAC REHABILITATION	0	0			76.97		
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	12,082			200.00		
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0				201.00		
202.00		Net Charges (line 200 - line 201)	0	12,082			202.00		

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0011 Component CCN: 14-T011		Period: From 04/01/2018 To 03/31/2019		Worksheet D Part II Date/Time Prepared: 8/16/2019 10:56 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,899,732	111,758,165	0.034894	85,877	2,997	50.00	
51.00	05100	RECOVERY ROOM	163,942	8,688,372	0.018869	10,472	198	51.00	
53.00	05300	ANESTHESIOLOGY	79,135	17,138,694	0.004617	12,417	57	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	969,427	38,227,743	0.025359	235,788	5,979	54.00	
56.00	05600	RADIOISOTOPE	68,440	22,748,534	0.003009	6,282	19	56.00	
57.00	05700	CT SCAN	430,572	86,659,880	0.004969	352,761	1,753	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	355,321	26,528,942	0.013394	75,462	1,011	58.00	
60.00	06000	LABORATORY	591,427	104,471,361	0.005661	1,116,792	6,322	60.00	
65.00	06500	RESPIRATORY THERAPY	218,301	9,765,759	0.022354	502,172	11,226	65.00	
66.00	06600	PHYSICAL THERAPY	418,307	42,005,233	0.009958	6,412,125	63,852	66.00	
69.00	06900	ELECTROCARDIOLOGY	248,867	32,113,783	0.007750	101,338	785	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,318	23,017,279	0.001534	27,317	42	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,884	21,942,379	0.003185	8,750	28	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	231,747	32,925,010	0.007039	1,685,863	11,867	73.00	
76.97	07697	CARDIAC REHABILITATION	84,697	2,626,555	0.032246	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	37,069	3,658,637	0.010132	3,228	33	90.00	
91.00	09100	EMERGENCY	630,451	43,563,367	0.014472	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,424,040	0.000000	0	0	92.00	
200.00		Total (lines 50 through 199)	8,532,637	632,263,733		10,636,644	106,169	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011 Component CCN: 14-T011		Period: From 04/01/2018 To 03/31/2019		Worksheet D Part IV Date/Time Prepared: 8/16/2019 10:56 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
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	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: 14-0011 Component CCN: 14-T011		Period: From 04/01/2018 To 03/31/2019		Worksheet D Part IV Date/Time Prepared: 8/16/2019 10:56 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	111,758,165	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	8,688,372	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	17,138,694	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,227,743	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	22,748,534	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	86,659,880	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	26,528,942	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	104,471,361	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,765,759	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	42,005,233	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	32,113,783	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	23,017,279	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,942,379	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	32,925,010	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,626,555	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	3,658,637	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	43,563,367	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,424,040	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	632,263,733		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011 Component CCN: 14-T011		Period: From 04/01/2018 To 03/31/2019		Worksheet D Part IV Date/Time Prepared: 8/16/2019 10:56 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	85,877	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	10,472	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.000000	12,417	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	235,788	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0.000000	6,282	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	352,761	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	75,462	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	1,116,792	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	502,172	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	6,412,125	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	101,338	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	27,317	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	8,750	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	1,685,863	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	3,228	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)			10,636,644	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011 Component CCN: 14-T011		Period: From 04/01/2018 To 03/31/2019	Worksheet D Part IV Date/Time Prepared: 8/16/2019 10:56 am
				Title XVIII		Subprovider - IRF	PPS
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost			
			21.00	24.00			
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
56.00	05600	RADIOISOTOPE	0	0			56.00
57.00	05700	CT SCAN	0	0			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
60.00	06000	LABORATORY	0	0			60.00
65.00	06500	RESPIRATORY THERAPY	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			73.00
76.97	07697	CARDIAC REHABILITATION	0	0			76.97
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		Total (lines 50 through 199)	0	0			200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part I
Date/Time Prepared:
8/16/2019 10:56 am

			Title XIX		Hospital	Cost	
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	1,966,543	0	1,966,543	21,238	92.60	30.00
31.00	INTENSIVE CARE UNIT	408,143		408,143	2,219	183.93	31.00
41.00	SUBPROVIDER - IRF	833,957	0	833,957	7,103	117.41	41.00
200.00	Total (lines 30 through 199)	3,208,643		3,208,643	30,560		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	803	74,358				30.00
31.00	INTENSIVE CARE UNIT	90	16,554				31.00
41.00	SUBPROVIDER - IRF	297	34,871				41.00
200.00	Total (lines 30 through 199)	1,190	125,783				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part II
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			Title XIX		Hospital		Cost	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,899,732	0	0.000000	0	0	50.00
51.00	05100	RECOVERY ROOM	163,942	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	79,135	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	969,427	0	0.000000	0	0	54.00
56.00	05600	RADIOISOTOPE	68,440	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	430,572	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	355,321	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	591,427	0	0.000000	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	218,301	0	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	418,307	0	0.000000	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	248,867	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,318	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,884	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	231,747	0	0.000000	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	84,697	0	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	37,069	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	630,451	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	8,532,637	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0011		Period: From 04/01/2018 To 03/31/2019		Worksheet D Part III Date/Time Prepared: 8/16/2019 10:56 am	
					Title XIX		Hospital		Cost	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	0	0	41.00
200.00		Total (lines 30 through 199)		0	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	21,238	0.00		803	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	2,219	0.00		90	31.00
41.00	04100	SUBPROVIDER - IRF		0	0	7,103	0.00		297	41.00
200.00		Total (lines 30 through 199)		0	0	30,560			1,190	200.00
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
					9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0					30.00
31.00	03100	INTENSIVE CARE UNIT		0	0					31.00
41.00	04100	SUBPROVIDER - IRF		0	0					41.00
200.00		Total (lines 30 through 199)		0	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet D
Part IV
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description		Title XIX		Hospital		Cost	
		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	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/16/2019 10:56 am

				Title XIX		Hospital	Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet D
Part IV
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description			Title XIX		Hospital		Cost	
			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	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	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	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
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)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011		Period: From 04/01/2018 To 03/31/2019	Worksheet D Part IV Date/Time Prepared: 8/16/2019 10:56 am
				Title XIX		Hospital	Cost
Cost Center Description				PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
				21.00	24.00		
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
56.00	05600	RADIOISOTOPE	0	0			56.00
57.00	05700	CT SCAN	0	0			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
60.00	06000	LABORATORY	0	0			60.00
65.00	06500	RESPIRATORY THERAPY	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			73.00
76.97	07697	CARDIAC REHABILITATION	0	0			76.97
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		Total (lines 50 through 199)	0	0			200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet D-1

Date/Time Prepared:
8/16/2019 10:56 am

Title XVIII		Hospital	PPS
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	21,238	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,238	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)	19,177	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)	11,360	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)	21,889,180	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)	21,889,180	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)	21,889,180	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,030.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	11,708,298	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)	11,708,298	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet D-1

Date/Time Prepared:
8/16/2019 10:56 am

		Title XVIII		Hospital	PPS		
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		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	3,954,190	2,219	1,781.97	1,366	2,434,171	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)					17,793,046	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					31,935,515	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,303,184	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,321,835	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,625,019	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					29,310,496	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					2,061	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,030.66	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,124,190	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet D-1

Date/Time Prepared:
8/16/2019 10:56 am

		Title XVIII		Hospital		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,966,543	21,889,180	0.089841	2,124,190	190,839	90.00
91.00	Nursing School cost	0	21,889,180	0.000000	2,124,190	0	91.00
92.00	Allied health cost	0	21,889,180	0.000000	2,124,190	0	92.00
93.00	All other Medical Education	0	21,889,180	0.000000	2,124,190	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2018 To 03/31/2019	Worksheet D-1 Date/Time Prepared: 8/16/2019 10:56 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,103	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,103	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)		7,103	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)		4,802	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)		8,177,971	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)		8,177,971	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)		8,177,971	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,151.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,528,735	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)		5,528,735	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0011

Period:

Worksheet D-1

Component CCN: 14-T011

From 04/01/2018

Date/Time Prepared:

To 03/31/2019

8/16/2019 10:56 am

Title XVIII

Subprovider -

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	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 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)					2,629,776	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,158,511	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)					563,803	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					106,169	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					669,972	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,488,539	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: 14-0011 Component CCN: 14-T011		Period: From 04/01/2018 To 03/31/2019		Worksheet D-1 Date/Time Prepared: 8/16/2019 10:56 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
			1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00	Capital-related cost		833,957	8,177,971	0.101976	0	0	90.00
91.00	Nursing School cost		0	8,177,971	0.000000	0	0	91.00
92.00	Allied health cost		0	8,177,971	0.000000	0	0	92.00
93.00	All other Medical Education		0	8,177,971	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0011	Period: From 04/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 8/16/2019 10:56 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		10,393,173		30.00
31.00	03100	INTENSIVE CARE UNIT		1,999,824		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.178379	18,221,361	3,250,308	50.00
51.00	05100	RECOVERY ROOM	0.182809	1,806,509	330,246	51.00
53.00	05300	ANESTHESIOLOGY	0.073290	2,687,969	197,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155366	2,581,180	401,028	54.00
56.00	05600	RADIOISOTOPE	0.086999	1,738,182	151,220	56.00
57.00	05700	CT SCAN	0.026339	11,728,883	308,927	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.060244	2,025,289	122,012	58.00
60.00	06000	LABORATORY	0.097801	14,757,583	1,443,306	60.00
65.00	06500	RESPIRATORY THERAPY	0.266977	4,319,738	1,153,271	65.00
66.00	06600	PHYSICAL THERAPY	0.274678	3,005,421	825,523	66.00
69.00	06900	ELECTROCARDIOLOGY	0.085897	5,870,226	504,235	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.174634	4,620,504	806,897	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.373435	7,383,852	2,757,389	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.319515	13,290,494	4,246,512	73.00
76.97	07697	CARDIAC REHABILITATION	0.347334	1,694	588	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.202270	108,818	22,011	90.00
91.00	09100	EMERGENCY	0.183399	5,858,775	1,074,493	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.480147	412,538	198,079	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		100,419,016	17,793,046	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)		100,419,016		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 8/16/2019 10:56 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		8,817,284		41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.178379	85,877	15,319	50.00
51.00	05100 RECOVERY ROOM	0.182809	10,472	1,914	51.00
53.00	05300 ANESTHESIOLOGY	0.073290	12,417	910	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.155366	235,788	36,633	54.00
56.00	05600 RADIOISOTOPE	0.086999	6,282	547	56.00
57.00	05700 CT SCAN	0.026339	352,761	9,291	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.060244	75,462	4,546	58.00
60.00	06000 LABORATORY	0.097801	1,116,792	109,223	60.00
65.00	06500 RESPIRATORY THERAPY	0.266977	502,172	134,068	65.00
66.00	06600 PHYSICAL THERAPY	0.274678	6,412,125	1,761,270	66.00
69.00	06900 ELECTROCARDIOLOGY	0.085897	101,338	8,705	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.174634	27,317	4,770	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.373435	8,750	3,268	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.319515	1,685,863	538,659	73.00
76.97	07697 CARDIAC REHABILITATION	0.347334	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.202270	3,228	653	90.00
91.00	09100 EMERGENCY	0.183399	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.480147	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		10,636,644	2,629,776	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)		10,636,644		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet E
Part A
Date/Time Prepared:
8/16/2019 10:56 am

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			11,554,438	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			12,288,665	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)			443,302	2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			79.35	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C) .			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			7.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)			16.90	31.00
32.00	Sum of lines 30 and 31			23.90	32.00
33.00	Allowable disproportionate share percentage (see instructions)			8.93	33.00
34.00	Disproportionate share adjustment (see instructions)			532,298	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011	Period: From 04/01/2018 To 03/31/2019	Worksheet E Part A Date/Time Prepared: 8/16/2019 10:56 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		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)	704,701	1,038,947	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	353,316	518,050	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	871,366		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 and 685. (see instructions)		0	0 41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 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 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	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)	25,690,069		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	29,658,824		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		28,666,635	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,945,928	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		30,612,563	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		30,612,563	61.00
62.00	Deductibles billed to program beneficiaries		2,823,824	62.00
63.00	Coinsurance billed to program beneficiaries		114,271	63.00
64.00	Allowable bad debts (see instructions)		1,080,569	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		702,370	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		767,533	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		28,376,838	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)		-7,138	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-68,589	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-60,946	70.93
70.94	HRR adjustment amount (see instructions)		-551,457	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet E
Part A
Date/Time Prepared:
8/16/2019 10:56 am

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	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	0	70.97
70.98	Low Volume Payment-3		0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		27,688,708	71.00	
71.01	Sequestration adjustment (see instructions)		553,774	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		30,027,178	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)		-2,892,244	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		51,537	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)	1,492,360	1,484,206	100.00	
HVB Adjustment for HSP Bonus Payment					
101.00	HVB adjustment factor (see instructions)	1.0023079974	0.9928703878	101.00	
102.00	HVB adjustment amount for HSP bonus payment (see instructions)	3,444	-10,582	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.9795	0.9744	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-30,593	-37,996	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	
Comparison 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 DSH PAYMENT PERCENTAGE

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet DSH

Date/Time Prepared:
8/16/2019 10:56 am

		Title XVIII		Hospital		PPS	
		Original .mcrcx Values	Adjusted .mcrcx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	7.00	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	16.90	0.00			16.90	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	23.90	0.00			16.90	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	MDH				MDH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	79.35	0.00			79.35	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	8.93	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	4.36	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	754	0			754	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	139	0			139	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	2,558	0			2,558	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	165	0			165	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	3,616	0			3,616	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	21,396	0			21,396	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	21,396	0			21,396	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	16.90	0.00			16.90	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0011		Period: From 04/01/2018 To 03/31/2019		Worksheet DSH Date/Time Prepared: 8/16/2019 10:56 am	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	8.93		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	True	29.00
30.00	Line 28 or 29 as applicable		8.93		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		8.93		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	True				True	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet DSH

Date/Time Prepared:
8/16/2019 10:56 am

Title XVIII

Hospital

PPS

		Revised		
		Percentage		
		6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	3.73		29.00
30.00	Line 28 or 29 as applicable	3.73		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011	Period: From 04/01/2018 To 03/31/2019	Worksheet E Part B Date/Time Prepared: 8/16/2019 10:56 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		12,082	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		16,318,383	2.00
3.00	OPPS payments		12,666,987	3.00
4.00	Outlier payment (see instructions)		34,224	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.804	5.00
6.00	Line 2 times line 5		13,119,980	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		96.81	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)		12,082	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		37,815	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)		37,815	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)		37,815	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		25,733	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)		12,082	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)		12,701,211	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,597,717	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)		10,115,576	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)		10,115,576	30.00
31.00	Primary payer payments		99	31.00
32.00	Subtotal (line 30 minus line 31)		10,115,477	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)		869,531	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		565,195	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		682,473	36.00
37.00	Subtotal (see instructions)		10,680,672	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)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		10,680,672	40.00
40.01	Sequestration adjustment (see instructions)		213,613	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		10,373,680	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		93,379	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: 14-0011	Period: From 04/01/2018 To 03/31/2019	Worksheet E Part B Date/Time Prepared: 8/16/2019 10:56 am	
		Title XVIII	Hospital	PPS	
				Overrides	
				1.00	
WORKSHEET OVERRIDE VALUES					
112.00	Override of Ancillary service charges (line 12)				0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/16/2019 10:56 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		28,637,149		10,388,530	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		03/25/2019	1,390,029		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	03/25/2019	14,850	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)		1,390,029		-14,850	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)		30,027,178		10,373,680	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		93,379	6.01
6.02	SETTLEMENT TO PROGRAM		2,892,244		0	6.02
7.00	Total Medicare program liability (see instructions)		27,134,934		10,467,059	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: 14-0011
 Component CCN: 14-T011

 Period:
 From 04/01/2018
 To 03/31/2019

 Worksheet E-1
 Part I
 Date/Time Prepared:
 8/16/2019 10:56 am

		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider					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		6,558,768			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		03/25/2019	16,422			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)		-16,422			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)		6,542,346			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		37,690			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		6,580,036			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: 14-0011	Period: From 04/01/2018 To 03/31/2019	Worksheet E-1 Part II Date/Time Prepared: 8/16/2019 10:56 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2018 To 03/31/2019	Worksheet E-3 Part III Date/Time Prepared: 8/16/2019 10:56 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
	PART III - MEDICARE PART A SERVICES - IRF PPS			
1.00	Net Federal PPS Payment (see instructions)			5,521,695 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0436 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			310,319 3.00
4.00	Outlier Payments			942,905 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			19.460274 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			6,774,919 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			6,774,919 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			6,774,919 19.00
20.00	Deductibles			59,224 20.00
21.00	Subtotal (line 19 minus line 20)			6,715,695 21.00
22.00	Coinsurance			24,904 22.00
23.00	Subtotal (line 21 minus line 22)			6,690,791 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			36,201 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			23,531 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			35,085 26.00
27.00	Subtotal (sum of lines 23 and 25)			6,714,322 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			6,714,322 32.00
32.01	Sequestration adjustment (see instructions)			134,286 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			6,542,346 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			37,690 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			942,905 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

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

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet G

Date/Time Prepared:
8/16/2019 10:56 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	97,270	0	7,874	0	1.00
2.00 Temporary investments	55,348	0	0	0	2.00
3.00 Notes receivable	20,000	0	0	0	3.00
4.00 Accounts receivable	113,694,802	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-85,696,815	0	0	0	6.00
7.00 Inventory	2,704,562	0	0	0	7.00
8.00 Prepaid expenses	375,281	0	0	0	8.00
9.00 Other current assets	556,154	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)	31,806,602	0	7,874	0	11.00
FIXED ASSETS					
12.00 Land	4,989,120	0	0	0	12.00
13.00 Land improvements	5,766,536	0	0	0	13.00
14.00 Accumulated depreciation	-3,593,801	0	0	0	14.00
15.00 Buildings	95,734,401	0	0	0	15.00
16.00 Accumulated depreciation	-50,716,390	0	0	0	16.00
17.00 Leasehold improvements	26,804	0	0	0	17.00
18.00 Accumulated depreciation	-11,579	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	250,962	0	0	0	21.00
22.00 Accumulated depreciation	-230,503	0	0	0	22.00
23.00 Major movable equipment	34,759,083	0	0	0	23.00
24.00 Accumulated depreciation	-21,902,692	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	65,071,941	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	999	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	1,487,560	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	1,488,559	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	98,367,102	0	7,874	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	3,340,413	0	0	0	37.00
38.00 Salaries, wages, and fees payable	5,739,857	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	715,020	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	5,990,804	0	0	0	43.00
44.00 Other current liabilities	1,273,898	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	17,059,992	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	42,927,618	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	694,317	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	43,621,935	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	60,681,927	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	37,685,175	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	7,874	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	37,685,175	0	7,874	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	98,367,102	0	7,874	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet G-1

Date/Time Prepared:
8/16/2019 10:56 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		43,627,016		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,941,844				2.00
3.00	Total (sum of line 1 and line 2)		37,685,172		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	ROUNDING	3		0		0	5.00
6.00		0		0		0	6.00
7.00	RESTRICTED DONATION	0		0		9,488	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)		3		0		10.00
11.00	Subtotal (line 3 plus line 10)		37,685,175		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00	RESTRICTED TRANSACTIONS	0		0		7,787	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)		37,685,175		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	6,173		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)	6,173		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	ROUNDING		0				5.00
6.00			0				6.00
7.00	RESTRICTED DONATION		0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	9,488		0			10.00
11.00	Subtotal (line 3 plus line 10)	15,661		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00	RESTRICTED TRANSACTIONS		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)	7,787		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	7,874		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/16/2019 10:56 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	22,919,911		22,919,911	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	13,154,407		13,154,407	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	36,074,318		36,074,318	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,489,981		3,489,981	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,489,981		3,489,981	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	39,564,299		39,564,299	17.00
18.00	Ancillary services	205,725,406	436,887,207	642,612,613	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	245,289,705	436,887,207	682,176,912	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		132,014,717		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		132,014,717		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019

Worksheet G-3

Date/Time Prepared:
8/16/2019 10:56 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	682,176,912	1.00
2.00	Less contractual allowances and discounts on patients' accounts	503,519,047	2.00
3.00	Net patient revenues (line 1 minus line 2)	178,657,865	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	132,014,717	4.00
5.00	Net income from service to patients (line 3 minus line 4)	46,643,148	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,800	6.00
7.00	Income from investments	2,151,467	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	6,736	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	592,438	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	1,502	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	62,036	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	619,697	22.00
23.00	Governmental appropriations	52,061	23.00
24.00	DEPARTMENTAL, MISC., PHO INCENTIVE	9,253	24.00
25.00	Total other income (sum of lines 6-24)	3,496,990	25.00
26.00	Total (line 5 plus line 25)	50,140,138	26.00
27.00	CORP. ALLOC., CONTRIBUTIONS	56,081,982	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	56,081,982	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-5,941,844	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0011

Period:
From 04/01/2018
To 03/31/2019Worksheet L
Parts I-III
Date/Time Prepared:
8/16/2019 10:56 am

Title XVIII		Hospital	PPS
			1.00
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	1,913,972	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	31,956	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)	58.62	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,945,928	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