

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: 14-0033	Period: From 03/01/2018 To 03/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/30/2019 2:33 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 8/30/2019	Time: 2:33 pm
	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	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	number of times reopened = 0-9.
	(4) Reopened		
	(5) Amended		

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 LAKE BEHAVIORAL HOSPITAL (14-0033) for the cost reporting period beginning 03/01/2018 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	0	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	0	0	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: 14-0033		Period: From 03/01/2018 To 03/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/30/2019 2:33 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 2615 WASHINGTON ST			PO Box:				1.00		
2.00	City: WAUKEGAN			State: IL		Zip Code: 60085		County: LAKE		
		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		LAKE BEHAVIORAL HOSPITAL	140033	29404	1	07/01/1966	N	P	O
4.00	Subprovider - IPF		PSYCH UNIT	14S033	29404	4	01/01/1990	N	P	O
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
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)						03/01/2018	03/31/2019		20.00
21.00	Type of Control (see instructions)						5			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0033

Period:
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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	45.00
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	48.00
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		57.00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)				N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0033

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From 03/01/2018
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Part I
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	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	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		N	N	0	71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0033	Period: From 03/01/2018 To 03/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/30/2019 2:33 pm	
				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	N	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	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
			Physical	Occupational	Speech
			1.00	2.00	3.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N
					Respiratory
					4.00
					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

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		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.	Y	E	93
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:	17,715	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	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
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)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0033		Period: From 03/01/2018 To 03/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/30/2019 2:33 pm		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name:	Contractor's Name:		Contractor's Number:						
142.00	Street:	PO Box:								
143.00	City:	State:		Zip Code:						
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	
								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	155.00			
156.00	Subprovider - IPF	N	N	N	N	N	156.00			
157.00	Subprovider - IRF	N	N	N	N	N	157.00			
158.00	SUBPROVIDER						158.00			
159.00	SNF	N	N	N	N	N	159.00			
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00			
161.00	CMHC		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			
								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.								N	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)									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)								0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0033	Period: From 03/01/2018 To 03/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/30/2019 2:33 pm
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 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)	N		3.00
		Y/N 1.00	Type 2.00	Date 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.	N		5.00
			Y/N 1.00	Legal Oper. 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.	N		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 1.00	Date 2.00	Y/N 3.00
				Date 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	08/27/2019	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: 14-0033	Period: From 03/01/2018 To 03/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/30/2019 2:33 pm
	Description	Y/N	Y/N	
	0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N	N	20.00
	Y/N	Date	Y/N	Date
	1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	21.00
			1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		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.	WADE	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BRADLEY ASSOCIATES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-237-5500	WADEH@BRADLEYCPA.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/30/2019 2:33 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/30/2019 2:33 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	0	0	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)		0	0	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	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)		0	0	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	46	18,216		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			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)		46			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: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/30/2019 2:33 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	0	0	0			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	5,216				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	0	0			7.00
8.00	INTENSIVE CARE UNIT	0	0	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)	0	0	0	0.00	68.38	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,911	429	11,493	0.00	32.73	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	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	101.11	27.00
28.00	Observation Bed Days		0	0			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: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/30/2019 2:33 pm

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	0	0	0	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				572		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	0	0	0	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	154	83	1,230	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					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: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/30/2019 2:33 pm

	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	5,054,362	0	5,054,362	153,182.00	33.00
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		0	0	0	0.00	0.00
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)		2,473,492	0	2,473,492	73,320.88	33.74
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00
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		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
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)		567,402	0	567,402		
18.00	Wage-related costs (other) (see instructions)		22,811	0	22,811		
19.00	Excluded areas		543,795	0	543,795		
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		0	0	0		
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)		0	0	0		
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	22,797	0	22,797	193.75	117.66
27.00	Administrative & General	5.00	1,405,674	0	1,405,674	39,987.23	35.15

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HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/30/2019 2:33 pm

		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.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	283,567	0	283,567	16,195.17	17.51	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	342,593	0	342,593	5,327.75	64.30	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	53,893	0	53,893	2,135.75	25.23	41.00
42.00	Social Service	17.00	309,377	0	309,377	10,085.73	30.67	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet S-3
Part III
Date/Time Prepared:
8/30/2019 2:33 pm

	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)	5,054,362	0	5,054,362	153,182.00	33.00	1.00
2.00	Excluded area salaries (see instructions)	2,473,492	0	2,473,492	73,320.88	33.74	2.00
3.00	Subtotal salaries (line 1 minus line 2)	2,580,870	0	2,580,870	79,861.12	32.32	3.00
4.00	Subtotal other wages & related costs (see inst.)	0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)	590,213	0	590,213	0.00	22.87	5.00
6.00	Total (sum of lines 3 thru 5)	3,171,083	0	3,171,083	79,861.12	39.71	6.00
7.00	Total overhead cost (see instructions)	2,417,901	0	2,417,901	73,925.38	32.71	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet S-3
Part IV
Date/Time Prepared:
8/30/2019 2:33 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	57,647	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)	418,165	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	10,479	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	10,006	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)	9,044	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	9,474	14.00
15.00	'Workers' Compensation Insurance	163,710	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	343,681	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	88,991	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,111,197	24.00
Part B - Other than Core Related Cost			
25.00	EMPLOYEE FUNCTIONS	9,870	25.00
25.01	RECRUITMENT EXPENSE	11,364	25.01
25.02	DEPARTMENT SUPPLIES	516	25.02
25.03	OTHER BENEFIT EXP	1,061	25.03

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet S-3
Part V
Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	1,111,197	1.00
2.00	Hospital	0	567,402	2.00
3.00	Subprovider - IPF	0	543,795	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0033	Period: From 03/01/2018 To 03/31/2019	Worksheet S-10 Date/Time Prepared: 8/30/2019 2:33 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.000000	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		86,560	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		10,086,071	6.00
7.00	Medicaid cost (line 1 times line 6)		0	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)		0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	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)	281,176	0	281,176 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	0	0	0 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		799,888	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		0	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		0	27.01
28.00	Non-Medicare bad debt expense (see instructions)		799,888	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		0	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		0	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		0	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0033

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

Worksheet A

Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification 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		353,923	353,923	0	353,923 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		197,442	197,442	0	197,442 2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	22,797	1,134,010	1,156,807	0	1,156,807 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,405,674	3,379,702	4,785,376	0	4,785,376 5.00
7.00	00700	OPERATION OF PLANT	283,567	1,513,367	1,796,934	0	1,796,934 7.00
9.00	00900	HOUSEKEEPING	0	316,349	316,349	0	316,349 9.00
10.00	01000	DIETARY	0	457,432	457,432	0	457,432 10.00
13.00	01300	NURSING ADMINISTRATION	342,593	12,155	354,748	0	354,748 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	53,893	17,715	71,608	0	71,608 16.00
17.00	01700	SOCIAL SERVICE	309,377	136,370	445,747	0	445,747 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
40.00	04000	SUBPROVIDER - IPF	2,473,492	1,683,913	4,157,405	0	4,157,405 40.00
ANCILLARY SERVICE COST CENTERS							
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	162,969	27,526	190,495	0	190,495 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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0 113.00
116.00	11600	HOSPICE	0	0	0	0	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,054,362	9,229,904	14,284,266	0	14,284,266 118.00
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	0	0	0	0 192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	5,054,362	9,229,904	14,284,266	0	14,284,266 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0033

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

Worksheet A

Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	353,923	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-2,819	194,623	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,156,807	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,818,681	1,966,695	5.00
7.00	00700	OPERATION OF PLANT	0	1,796,934	7.00
9.00	00900	HOUSEKEEPING	0	316,349	9.00
10.00	01000	DIETARY	-48	457,384	10.00
13.00	01300	NURSING ADMINISTRATION	0	354,748	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-140	71,468	16.00
17.00	01700	SOCIAL SERVICE	0	445,747	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	-629,093	3,528,312	40.00
ANCILLARY SERVICE COST CENTERS					
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	190,495	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,450,781	10,833,485	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
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,450,781	10,833,485	200.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet A-7
Part I
Date/Time Prepared:
8/30/2019 2:33 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	0	878,281	0	878,281	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	0	983,666	0	983,666	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	0	207,330	0	207,330	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	0	2,069,277	0	2,069,277	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	0	2,069,277	0	2,069,277	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	878,281	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	983,666	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	207,330	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	2,069,277	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	2,069,277	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet A-7
Part II
Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	28,923	0	0	0	325,000	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	65,050	14,198	2,650	115,544	0	2.00
3.00	Total (sum of lines 1-2)	93,973	14,198	2,650	115,544	325,000	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	353,923				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	197,442				2.00
3.00	Total (sum of lines 1-2)	0	551,365				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet A-7
Part III
Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
		1.00	2.00	3.00	4.00	5.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,861,947	0	1,861,947	0.899806	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	207,330	0	207,330	0.100194	0	2.00	
3.00	Total (sum of lines 1-2)	2,069,277	0	2,069,277	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	28,923	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	65,050	14,198	2.00	
3.00	Total (sum of lines 1-2)	0	0	0	93,973	14,198	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	325,000	0	353,923	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	-169	115,544	0	0	194,623	2.00	
3.00	Total (sum of lines 1-2)	-169	115,544	325,000	0	548,546	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0033

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

Worksheet A-8

Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-2,819	CAP REL COSTS-MVBLE EQUIP	2.00	11	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	-629,093			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-140	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		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	REBATES	B	-48	DIETARY	10.00	0	33.00

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ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0033

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

Worksheet A-8

Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.01
33.02	OTHER MISC INCOME	B	-67,980	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.03
33.04	ADVERTISING	A	-13,751	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	LOBBYING	A	-2,413	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	HAF	A	-2,734,537	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,450,781				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0033

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

Worksheet A-8-2

Date/Time Prepared:
8/30/2019 2:33 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	40.00	DR. A	629,093	629,093	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			629,093	629,093	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	40.00	DR. A	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	40.00	DR. A	0	0	0	629,093		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	629,093		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	353,923	353,923			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	194,623		194,623		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,156,807	1,151	633	1,158,591	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,966,695	79,704	43,829	323,678	5.00
7.00	00700	OPERATION OF PLANT	1,796,934	141,368	77,740	65,296	7.00
9.00	00900	HOUSEKEEPING	316,349	804	442	0	9.00
10.00	01000	DIETARY	457,384	0	0	0	10.00
13.00	01300	NURSING ADMINISTRATION	354,748	881	484	78,887	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	71,468	4,906	2,698	12,410	16.00
17.00	01700	SOCIAL SERVICE	445,747	881	484	71,239	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,528,312	106,481	58,554	569,555	40.00
ANCILLARY SERVICE COST CENTERS							
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
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
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	190,495	17,747	9,759	37,526	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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,833,485	353,923	194,623	1,158,591	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,833,485	353,923	194,623	1,158,591	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			5.00	7.00	9.00	10.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	2,413,906					5.00
7.00	00700	OPERATION OF PLANT	596,724	2,678,062				7.00
9.00	00900	HOUSEKEEPING	91,055	16,347	424,997			9.00
10.00	01000	DIETARY	131,133	0	0	588,517		10.00
13.00	01300	NURSING ADMINISTRATION	124,715	17,915	2,860	0	580,490	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,228	99,764	15,929	0	0	16.00
17.00	01700	SOCIAL SERVICE	148,612	17,915	2,860	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,222,179	2,165,247	345,727	588,517	580,490	40.00
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	73,260	360,874	57,621	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,413,906	2,678,062	424,997	588,517	580,490	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	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,413,906	2,678,062	424,997	588,517	580,490	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	233,403					16.00
17.00	01700	SOCIAL SERVICE	0	687,738				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	218,420	687,738	10,071,220	0	10,071,220	40.00
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	14,983	0	762,265	0	762,265	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	233,403	687,738	10,833,485	0	10,833,485	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	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	233,403	687,738	10,833,485	0	10,833,485	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0033

Period:
From 03/01/2018
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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	1,151	633	1,784	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	79,704	43,829	123,533	5.00
7.00	00700	OPERATION OF PLANT	0	141,368	77,740	219,108	7.00
9.00	00900	HOUSEKEEPING	0	804	442	1,246	9.00
10.00	01000	DIETARY	0	0	0	0	10.00
13.00	01300	NURSING ADMINISTRATION	0	881	484	1,365	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,906	2,698	7,604	16.00
17.00	01700	SOCIAL SERVICE	0	881	484	1,365	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	106,481	58,554	165,035	40.00
ANCILLARY SERVICE COST CENTERS							
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
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
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	17,747	9,759	27,506	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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	353,923	194,623	548,546	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	353,923	194,623	548,546	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet B
Part II
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			5.00	7.00	9.00	10.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	124,032					5.00
7.00	00700	OPERATION OF PLANT	30,660	249,869				7.00
9.00	00900	HOUSEKEEPING	4,678	1,525	7,449			9.00
10.00	01000	DIETARY	6,738	0	0	6,738		10.00
13.00	01300	NURSING ADMINISTRATION	6,408	1,672	50	0	9,617	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,348	9,308	279	0	0	16.00
17.00	01700	SOCIAL SERVICE	7,636	1,672	50	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	62,800	202,022	6,060	6,738	9,617	40.00
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,764	33,670	1,010	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	124,032	249,869	7,449	6,738	9,617	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	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	124,032	249,869	7,449	6,738	9,617	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,558					16.00
17.00	01700	SOCIAL SERVICE	0	10,833				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	17,367	10,833	481,347	0	481,347	40.00
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,191	0	67,199	0	67,199	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,558	10,833	548,546	0	548,546	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	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,558	10,833	548,546	0	548,546	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0033

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

Worksheet B-1

Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	64,276					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		64,276				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	209	209	5,031,565			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,475	14,475	1,405,674	-2,413,906	8,419,579	5.00
7.00	00700	OPERATION OF PLANT	25,674	25,674	283,567	0	2,081,338	7.00
9.00	00900	HOUSEKEEPING	146	146	0	0	317,595	9.00
10.00	01000	DIETARY	0	0	0	0	457,384	10.00
13.00	01300	NURSING ADMINISTRATION	160	160	342,593	0	435,000	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	891	891	53,893	0	91,482	16.00
17.00	01700	SOCIAL SERVICE	160	160	309,377	0	518,351	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	19,338	19,338	2,473,492	0	4,262,902	40.00
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,223	3,223	162,969	0	255,527	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	64,276	64,276	5,031,565	-2,413,906	8,419,579	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	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	353,923	194,623	1,158,591		2,413,906	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.506301	3.027926	0.230265		0.286702	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			1,784		124,032	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000355		0.014731	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: 14-0033

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

Worksheet B-1

Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			7.00	9.00	10.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	23,918					7.00
9.00	00900	HOUSEKEEPING	146	23,772				9.00
10.00	01000	DIETARY	0	0	34,479			10.00
13.00	01300	NURSING ADMINISTRATION	160	160	0	73,321		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	891	891	0	0	24,574,679	16.00
17.00	01700	SOCIAL SERVICE	160	160	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	19,338	19,338	34,479	73,321	22,997,229	40.00
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,223	3,223	0	0	1,577,450	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,918	23,772	34,479	73,321	24,574,679	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	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,678,062	424,997	588,517	580,490	233,403	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	111.968476	17.878050	17.068854	7.917104	0.009498	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	249,869	7,449	6,738	9,617	18,558	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.446902	0.313352	0.195423	0.131163	0.000755	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: 14-0033

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

Worksheet B-1

Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description		SOCIAL SERVICE	
		(TOTAL PATIENT DAYS)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
		11,493	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
		11,493	
ANCILLARY SERVICE COST CENTERS			
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
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
60.01	06001	BLOOD LABORATORY	60.01
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
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
74.00	07400	RENAL DIALYSIS	74.00
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
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	98.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		11,493	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
		687,738	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		59.839729	
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		10,833	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		0.942574	
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: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/30/2019 2:33 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0		0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	10,071,220		10,071,220	0	10,071,220	40.00
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
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
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	762,265		762,265	0	762,265	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	10,833,485	0	10,833,485	0	10,833,485	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	10,833,485	0	10,833,485	0	10,833,485	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/30/2019 2:33 pm

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
40.00	04000	SUBPROVIDER - IPF	22,997,229		22,997,229			40.00
ANCILLARY SERVICE COST CENTERS								
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
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
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,577,450	1,577,450	0.483226	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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	22,997,229	1,577,450	24,574,679			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,997,229	1,577,450	24,574,679			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
ANCILLARY SERVICE COST CENTERS						
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.483226			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000			98.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
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: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/30/2019 2:33 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE		Total Costs
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0		0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	10,071,220		10,071,220	0	10,071,220	40.00
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
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
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	762,265		762,265	0	762,265	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	10,833,485	0	10,833,485	0	10,833,485	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	10,833,485	0	10,833,485	0	10,833,485	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/30/2019 2:33 pm

			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
40.00	04000	SUBPROVIDER - IPF	22,997,229		22,997,229			40.00
ANCILLARY SERVICE COST CENTERS								
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
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
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,577,450	1,577,450	0.483226	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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	22,997,229	1,577,450	24,574,679			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,997,229	1,577,450	24,574,679			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
ANCILLARY SERVICE COST CENTERS						
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
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
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000			98.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
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: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet D
Part I
Date/Time Prepared:
8/30/2019 2:33 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0	0	0	0.00	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
40.00	SUBPROVIDER - IPF	481,347	0	481,347	11,493	41.88	40.00
200.00	Total (lines 30 through 199)	481,347		481,347	11,493		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	0	0				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
40.00	SUBPROVIDER - IPF	1,911	80,033				40.00
200.00	Total (lines 30 through 199)	1,911	80,033				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet D
Part II
Date/Time Prepared:
8/30/2019 2:33 pm

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							
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	58.00
60.00	06000	LABORATORY	0	0	0.000000	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	67,199	1,577,450	0.042600	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	98.00
200.00		Total (lines 50 through 199)	67,199	1,577,450		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0033		Period: From 03/01/2018 To 03/31/2019		Worksheet D Part III Date/Time Prepared: 8/30/2019 2:33 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
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	0	0.00	0	30.00			
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	11,493	0.00	1,911	40.00			
200.00		Total (lines 30 through 199)		0	11,493		1,911	200.00			
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
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
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
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: 14-0033 Period: From 03/01/2018 To 03/31/2019 Worksheet D Part IV Date/Time Prepared: 8/30/2019 2:33 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
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
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	1,577,450	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
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	1,577,450		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0033	Period: From 03/01/2018 To 03/31/2019	Worksheet D Part IV Date/Time Prepared: 8/30/2019 2:33 pm
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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							
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
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
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
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
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
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	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
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	142,725	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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Total (lines 50 through 199)		0	0	142,725	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet D
Part V
Date/Time Prepared:
8/30/2019 2:33 pm

			Title XVIII	Hospital	PPS		
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
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
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
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
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
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
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	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
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.483226	142,725	0	0	68,968	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
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.000000		0			95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Subtotal (see instructions)		142,725	0	0	68,968	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		142,725	0	0	68,968	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet D
Part V
Date/Time Prepared:
8/30/2019 2:33 pm

			Title XVIII		Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
ANCILLARY SERVICE COST CENTERS						
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00	
56.00	05600	RADIOISOTOPE	0	0	56.00	
57.00	05700	CT SCAN	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00	
60.00	06000	LABORATORY	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0	0	60.01	
65.00	06500	RESPIRATORY THERAPY	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	90.00	
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		95.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00	
200.00		Subtotal (see instructions)	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00	
202.00		Net Charges (line 200 - line 201)	0	0	202.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0033

Period:

Worksheet D

Component CCN: 14-S033

From 03/01/2018
To 03/31/2019Part II
Date/Time Prepared:
8/30/2019 2:33 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	0	0	0.000000	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0.000000	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0.000000	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	67,199	1,577,450	0.042600	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50 through 199)	67,199	1,577,450		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0033 Component CCN: 14-S033		Period: From 03/01/2018 To 03/31/2019		Worksheet D Part IV Date/Time Prepared: 8/30/2019 2:33 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0033 Component CCN: 14-S033		Period: From 03/01/2018 To 03/31/2019		Worksheet D Part IV Date/Time Prepared: 8/30/2019 2:33 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
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
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0.000000	55.00
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
60.01	06001	BLOOD LABORATORY		0	0	0	0	0.000000	60.01
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
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0.000000	70.00
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
74.00	07400	RENAL DIALYSIS		0	0	0	0	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	1,577,450	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
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS		0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)		0	0	0	1,577,450		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0033 Component CCN: 14-S033		Period: From 03/01/2018 To 03/31/2019		Worksheet D Part IV Date/Time Prepared: 8/30/2019 2:33 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
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
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
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
60.01	06001	BLOOD LABORATORY		0.000000	0	0	0	0	60.01
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
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	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
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
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
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS		0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0033

Period:

Worksheet D

Component CCN: 14-S033

From 03/01/2018
To 03/31/2019Part V
Date/Time Prepared:
8/30/2019 2:33 pm

Title XVIII

Subprovider -
IPF

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						
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
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0 55.00
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
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
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
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	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
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.483226	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
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.000000		0		0 95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0 98.00
200.00	Subtotal (see instructions)		0	0	0	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 - line 201)		0	0	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0033

Period:

Worksheet D

Component CCN: 14-S033

From 03/01/2018
To 03/31/2019Part V
Date/Time Prepared:
8/30/2019 2:33 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Costs			
		Cost	Cost		
		Reimbursed	Reimbursed		
		Services	Services Not		
		Subject To	Subject To		
		Ded. & Coins.	Ded. & Coins.		
		(see inst.)	(see inst.)		
		6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet D
Part V
Date/Time Prepared:
8/30/2019 2:33 pm

			Title XIX		Hospital		Cost	
	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							
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
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
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
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
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	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
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.483226	0	0	0	0	90.00
	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
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet D
Part V
Date/Time Prepared:
8/30/2019 2:33 pm

			Title XIX		Hospital	Cost
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0033

Period:

Worksheet D

Component CCN: 14-S033

From 03/01/2018
To 03/31/2019Part V
Date/Time Prepared:
8/30/2019 2:33 pm

Title XIX

Subprovider -
IPF

Cost

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						
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
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0 55.00
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
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
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
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	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
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.483226	0	64,675	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
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0 95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0 98.00
200.00	Subtotal (see instructions)		0	64,675	0	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 - line 201)		0	64,675	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0033

Period:

Worksheet D

Component CCN: 14-S033

From 03/01/2018
To 03/31/2019Part V
Date/Time Prepared:
8/30/2019 2:33 pm

Title XIX

Subprovider -
IPF

Cost

Cost Center Description			Costs		
			Cost	Cost	
			Reimbursed	Reimbursed	
			Services	Services Not	
			Subject To	Subject To	
			Ded. & Coins.	Ded. & Coins.	
			(see inst.)	(see inst.)	
			6.00	7.00	
ANCILLARY SERVICE COST CENTERS					
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	31,253	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00		Subtotal (see instructions)	31,253	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	31,253	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033	Period: From 03/01/2018 To 03/31/2019	Worksheet D-1 Date/Time Prepared: 8/30/2019 2:33 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			0 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			0 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)			0 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)			0 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)			0 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)			0 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)			0 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)			0.00 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			0 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)			0 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0033

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

Worksheet D-1

Date/Time Prepared:
8/30/2019 2:33 pm

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0033

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

Worksheet D-1

Date/Time Prepared:
8/30/2019 2:33 pm

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033 Component CCN: 14-S033	Period: From 03/01/2018 To 03/31/2019	Worksheet D-1 Date/Time Prepared: 8/30/2019 2:33 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		11,493	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,493	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)		11,493	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,911	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)		10,071,220	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)		10,071,220	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)		10,071,220	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)		876.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,674,590	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,674,590	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0033 Component CCN: 14-S033	Period: From 03/01/2018 To 03/31/2019	Worksheet D-1 Date/Time Prepared: 8/30/2019 2:33 pm
			Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	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)					0 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,674,590 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)					80,033 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					80,033 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,594,557 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: 14-0033

Period:

Worksheet D-1

Component CCN: 14-S033

From 03/01/2018

Date/Time Prepared:

To 03/31/2019

8/30/2019 2:33 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	481,347	10,071,220	0.047794	0	0	90.00
91.00	Nursing School cost	0	10,071,220	0.000000	0	0	91.00
92.00	Allied health cost	0	10,071,220	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,071,220	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033	Period: From 03/01/2018 To 03/31/2019	Worksheet D-1 Date/Time Prepared: 8/30/2019 2:33 pm	
		Title XIX	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			0	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)			0	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)			0	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)			0	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)			0	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)			0	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)			0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			0	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)			0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0033

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

Worksheet D-1

Date/Time Prepared:
8/30/2019 2:33 pm

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0033

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

Worksheet D-1

Date/Time Prepared:
8/30/2019 2:33 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0033	Period: From 03/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 8/30/2019 2:33 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
ANCILLARY SERVICE COST CENTERS					
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
60.00	06000	LABORATORY	0.000000	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.483226	0	90.00
91.00	09100	EMERGENCY	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	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)		0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0033	Period: From 03/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 8/30/2019 2:33 pm	
		Component CCN: 14-S033		Title XVIII Subprovider - IPF	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		3,820,239		40.00
ANCILLARY SERVICE COST CENTERS					
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.000000	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.483226	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0033	Period: From 03/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 8/30/2019 2:33 pm
			Title XIX	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
ANCILLARY SERVICE COST CENTERS					
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
60.00	06000	LABORATORY	0.000000	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.483226	0	90.00
91.00	09100	EMERGENCY	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	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)		0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0033 Component CCN: 14-S033	Period: From 03/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 8/30/2019 2:33 pm	
		Title XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		509,740		40.00
ANCILLARY SERVICE COST CENTERS					
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.000000	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.483226	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet E
Part A
Date/Time Prepared:
8/30/2019 2:33 pm

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			0	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)			0	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)			0.00	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)			0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)			0.00	31.00
32.00	Sum of lines 30 and 31			0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)			0.00	33.00
34.00	Disproportionate share adjustment (see instructions)			0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0033	Period: From 03/01/2018 To 03/31/2019	Worksheet E Part A Date/Time Prepared: 8/30/2019 2:33 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		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)		0		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			0	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			0	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)			0	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			0	61.00
62.00	Deductibles billed to program beneficiaries			0	62.00
63.00	Coinsurance billed to program beneficiaries			0	63.00
64.00	Allowable bad debts (see instructions)			0	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			0	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			0	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			0	70.93
70.94	HRR adjustment amount (see instructions)			0	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet E
Part A
Date/Time Prepared:
8/30/2019 2:33 pm

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			0	71.00
71.01	Sequestration adjustment (see instructions)			0	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			0	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)			0	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000		103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	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 REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0033	Period: From 03/01/2018 To 03/31/2019	Worksheet E Part B Date/Time Prepared: 8/30/2019 2:33 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		68,968	2.00
3.00	OPPS payments		62,152	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	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)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		0	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)		62,152	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		12,432	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		49,720	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)		49,720	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		49,720	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		49,720	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		49,720	40.00
40.01	Sequestration adjustment (see instructions)		994	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		48,726	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	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: 14-0033 Component CCN: 14-S033	Period: From 03/01/2018 To 03/31/2019	Worksheet E Part B Date/Time Prepared: 8/30/2019 2:33 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		0	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)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		0	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)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/30/2019 2:33 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		48,726	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		48,726	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		48,726	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: 14-0033

Period:

Worksheet E-1

Component CCN: 14-S033

From 03/01/2018
To 03/31/2019Part I
Date/Time Prepared:
8/30/2019 2:33 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,488,210		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,488,210		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,488,210		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		Provider CCN: 14-0033	Period: From 03/01/2018 To 03/31/2019	Worksheet E-3 Part II Date/Time Prepared: 8/30/2019 2:33 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART II - MEDICARE PART A SERVICES - IPF PPS					
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			0	1.00
2.00	Net IPF PPS Outlier Payments			0	2.00
3.00	Net IPF PPS ECT Payments			0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	4.01
5.00	New Teaching program adjustment. (see instructions)			0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)			0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)			0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00	8.00
9.00	Average Daily Census (see instructions)			0.000000	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			0	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)				14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0	15.00
16.00	Subtotal (see instructions)			0	16.00
17.00	Primary payer payments			0	17.00
18.00	Subtotal (line 16 less line 17).			0	18.00
19.00	Deductibles			0	19.00
20.00	Subtotal (line 18 minus line 19)			0	20.00
21.00	Coinsurance			0	21.00
22.00	Subtotal (line 20 minus line 21)			0	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	25.00
26.00	Subtotal (sum of lines 22 and 24)			0	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0	27.00
28.00	Other pass through costs (see instructions)			0	28.00
29.00	Outlier payments reconciliation			0	29.00
30.00	OTHER ADJUSTMENTS			0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	30.50
30.99	Demonstration payment adjustment amount before sequestration			0	30.99
31.00	Total amount payable to the provider (see instructions)			0	31.00
31.01	Sequestration adjustment (see instructions)			0	31.01
31.02	Demonstration payment adjustment amount after sequestration			0	31.02
32.00	Interim payments			0	32.00
33.00	Tentative settlement (for contractor use only)			0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	35.00
TO BE COMPLETED BY CONTRACTOR					
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
52.00	The rate used to calculate the Time Value of Money			0.00	52.00
53.00	Time Value of Money (see instructions)			0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0033 Component CCN: 14-S033	Period: From 03/01/2018 To 03/31/2019	Worksheet E-3 Part II Date/Time Prepared: 8/30/2019 2:33 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,666,301 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			29.022727 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,666,301 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,666,301 16.00
17.00	Primary payer payments			6,228 17.00
18.00	Subtotal (line 16 less line 17).			1,660,073 18.00
19.00	Deductibles			118,376 19.00
20.00	Subtotal (line 18 minus line 19)			1,541,697 20.00
21.00	Coinurance			23,115 21.00
22.00	Subtotal (line 20 minus line 21)			1,518,582 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,518,582 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,518,582 31.00
31.01	Sequestration adjustment (see instructions)			30,372 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,488,210 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			0 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet E-3
Part VII
Date/Time Prepared:
8/30/2019 2:33 pm

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

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

Provider CCN: 14-0033

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

Worksheet G

Date/Time Prepared:
8/30/2019 2:33 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	39,895	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,611,982	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,184,543	0	0	0	6.00
7.00	Inventory	24,766	0	0	0	7.00
8.00	Prepaid expenses	520,556	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	2,012,656	0	0	0	11.00
FIXED ASSETS						
12.00	Land	878,281	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	983,666	0	0	0	15.00
16.00	Accumulated depreciation	-26,545	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	207,330	0	0	0	19.00
20.00	Accumulated depreciation	-34,386	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	2,343,824	0	0	0	23.00
24.00	Accumulated depreciation	-33,041	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)	4,319,129	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	1,872,196	0	0	0	33.00
34.00	Other assets	173,583	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,045,779	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	8,377,564	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,187,209	0	0	0	37.00
38.00	Salaries, wages, and fees payable	472,731	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	59,026	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,718,966	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	44,364	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	44,364	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,763,330	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,614,234				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	5,614,234	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,377,564	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0033

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

Worksheet G-1

Date/Time Prepared:
8/30/2019 2:33 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,942,846				2.00
3.00	Total (sum of line 1 and line 2)		-2,942,846		0		3.00
4.00	OTHER ADDITIONS	8,557,080		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		8,557,080		0		10.00
11.00	Subtotal (line 3 plus line 10)		5,614,234		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,614,234		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	OTHER ADDITIONS		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0033

Period:
From 03/01/2018
To 03/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/30/2019 2:33 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	0		0	1.00
2.00	SUBPROVIDER - IPF	22,997,229		22,997,229	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	22,997,229		22,997,229	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,997,229		22,997,229	17.00
18.00	Ancillary services	0		0	18.00
19.00	Outpatient services	0	1,577,450	1,577,450	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PROFESSIONAL FEES	2,095,475	0	2,095,475	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	25,092,704	1,577,450	26,670,154	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,284,266		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)		14,284,266		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0033

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

Worksheet G-3

Date/Time Prepared:
8/30/2019 2:33 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	26,670,154	1.00
2.00	Less contractual allowances and discounts on patients' accounts	18,227,159	2.00
3.00	Net patient revenues (line 1 minus line 2)	8,442,995	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,284,266	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,841,271	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	6,257	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	48	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	140	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	BAD DEBT	-799,888	24.00
24.01	CHARITY	-281,176	24.01
24.02	ADMIN WRITE-OFFS	-388,024	24.02
24.03	OTHER MISC	67,980	24.03
24.04	SCHOOL INCOME	0	24.04
24.05	HFS ASSESSMENT FEE	4,293,088	24.05
24.06	OTHER (SPECIFY)	0	24.06
24.07	OTHER (SPECIFY)	0	24.07
24.08	OTHER (SPECIFY)	0	24.08
25.00	Total other income (sum of lines 6-24)	2,898,425	25.00
26.00	Total (line 5 plus line 25)	-2,942,846	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,942,846	29.00