

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: 14-0040	Period: From 05/01/2018 To 04/30/2019	Worksheet S Parts I-III Date/Time Prepared: 9/30/2019 10:39 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 9/30/2019	Time: 10:39 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GALESBURG COTTAGE HOSPITAL (14-0040) for the cost reporting period beginning 05/01/2018 and ending 04/30/2019 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) GARY SINGER

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-24,674	-11,315	0	0	1.00
2.00	Subprovider - IPF	0	26,639	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	1,965	-11,315	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: 14-0040		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part I Date/Time Prepared: 9/30/2019 10:39 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 695 NORTH KELLOGG STREET			PO Box:				1.00	
2.00	City: GALESBURG			State: IL		Zip Code: 61401		County: KNOX	
		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			GALESBURG COTTAGE HOSPITAL	140040	99914	1	07/06/1966	N
4.00	Subprovider - IPF			GALESBURG COTTAGE PSYCH	14S040	99914	4	05/01/2006	N
5.00	Subprovider - IRF								P
6.00	Subprovider - (Other)								P
7.00	Swing Beds - SNF								N
8.00	Swing Beds - NF								N
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)						05/01/2018	04/30/2019	
21.00	Type of Control (see instructions)						4		
							1.00	2.00	
							2.00	3.00	
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			242	338	0	0	1,375	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0040

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.					2		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.					2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					1		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					05/01/2018	04/30/2019	38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
					1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0040

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From 05/01/2018
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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		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0	76.00

MCRIF32 - 15.8.166.0

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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.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	50,976	-9,359	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.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HB0776	140.00

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1.00		2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name: COMMUNITY HEALTH SYSTEMS		Contractor's Name: WISCONSIN PHYSICIAN SERVICES		Contractor's Number: 52280	
142.00	Street: 4000 MERIDIAN BOULEVARD		PO Box:			
143.00	City: FRANKLIN		State: TN		Zip Code: 37067	
						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.				Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00
						1.00
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N
		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
156.00	Subprovider - IPF		N	N	N	N
157.00	Subprovider - IRF		N	N	N	N
158.00	SUBPROVIDER					
159.00	SNF		N	N	N	N
160.00	HOME HEALTH AGENCY		N	N	N	N
161.00	CMHC			N	N	N
						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
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
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.						Y
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
168.01 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)						
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99
				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)				05/01/2018	04/30/2019	
				1.00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)				N	0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0040		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part II Date/Time Prepared: 9/30/2019 10:39 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	08/15/2019	Y	08/15/2019
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: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
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9/30/2019 10:39 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		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?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2018	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.	JOSEPH	MORAN		41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615 221-3613	JOSEPH_MORAN@QUORUMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part II
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER, REIMBURSEMENT	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: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
9/30/2019 10:39 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	84	30,660	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)		84	30,660	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		96	35,040	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	16	5,840		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		112			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: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
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Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,339	103	5,060			1.00
2.00	HMO and other (see instructions)	1,192	1,713				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,339	103	5,060			7.00
8.00	INTENSIVE CARE UNIT	460	19	888			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		120	751			13.00
14.00	Total (see instructions)	2,799	242	6,699	0.00	232.67	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,393	5	3,831	0.00	21.66	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	254.33	27.00
28.00	Observation Bed Days		0	797			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	130			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: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
9/30/2019 10:39 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	663	48	1,754	1.00
2.00 HMO and other (see instructions)			225	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	663	48	1,754	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	121	2	188	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part II
Date/Time Prepared:
9/30/2019 10:39 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	15,153,356	0	15,153,356	529,012.00	28.64
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)		1,321,590	16,573	1,338,163	48,878.00	27.38
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,092,329	0	2,092,329	35,963.00	58.18
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		933,136	0	933,136	12,168.00	76.69
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)		3,440,385	0	3,440,385		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		352,181	0	352,181		
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	119,808	0	119,808	3,377.00	35.48
27.00	Administrative & General	5.00	2,092,470	-151,369	1,941,101	78,934.00	24.59

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part II
Date/Time Prepared:
9/30/2019 10:39 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	82,924	0	82,924	1,260.00	65.81	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	440,004	0	440,004	16,673.00	26.39	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	404,542	0	404,542	27,275.00	14.83	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	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	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	1,034,302	63,284	1,097,586	29,392.00	37.34	38.00
39.00	Central Services and Supply	86,651	0	86,651	5,812.00	14.91	39.00
40.00	Pharmacy	545,976	0	545,976	12,884.00	42.38	40.00
41.00	Medical Records & Medical Records Library	301,254	0	301,254	14,850.00	20.29	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part III
Date/Time Prepared:
9/30/2019 10:39 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	15,236,280	0	15,236,280	530,272.00	28.73	1.00
2.00	Excluded area salaries (see instructions)	1,321,590	16,573	1,338,163	48,878.00	27.38	2.00
3.00	Subtotal salaries (line 1 minus line 2)	13,914,690	-16,573	13,898,117	481,394.00	28.87	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,025,465	0	3,025,465	48,131.00	62.86	4.00
5.00	Subtotal wage-related costs (see inst.)	3,440,385	0	3,440,385	0.00	24.75	5.00
6.00	Total (sum of lines 3 thru 5)	20,380,540	-16,573	20,363,967	529,525.00	38.46	6.00
7.00	Total overhead cost (see instructions)	5,107,931	-88,085	5,019,846	190,457.00	26.36	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part IV
Date/Time Prepared:
9/30/2019 10:39 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	258,519	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)	0	8.02
8.03	Health Insurance (Purchased)	2,249,606	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	16,015	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	18,395	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-817	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	13,576	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	68,786	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	873,085	17.00
18.00	Medicare Taxes - Employers Portion Only	204,189	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	88,483	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)	3,789,837	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part V
Date/Time Prepared:
9/30/2019 10:39 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,092,329	3,789,837	1.00
2.00	Hospital	2,092,329	3,789,837	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet S-7

Date/Time Prepared:
9/30/2019 10:39 am

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	0	0	0 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	0	0 19.00
20.00		RHA	0	0	0 20.00
21.00		RMC	0	0	0 21.00
22.00		RMB	0	0	0 22.00
23.00		RMA	0	0	0 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	0	0 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	0	0 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	0	0 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet S-7

Date/Time Prepared:
9/30/2019 10:39 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).					201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet S-10

Date/Time Prepared:
9/30/2019 10:39 am

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.113102	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		3,937,369	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		2,997,147	5.00
6.00	Medicaid charges		81,126,035	6.00
7.00	Medicaid cost (line 1 times line 6)		9,175,517	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		2,241,001	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)		2,241,001	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)	1,616,093	0	1,616,093
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	182,783	0	182,783
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	182,783	0	182,783
			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)		2,361,800	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		248,048	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		381,612	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,980,188	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		357,527	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		540,310	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,781,311	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet A

Date/Time Prepared:
9/30/2019 10:39 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,401,777	1,401,777	540,971	1,942,748	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,699,764	1,699,764	456,167	2,155,931	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	119,808	87,628	207,436	2,626,552	2,833,988	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,092,470	14,411,583	16,504,053	-3,496,686	13,007,367	5.00
7.00	00700	OPERATION OF PLANT	440,004	1,917,126	2,357,130	0	2,357,130	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	136,958	136,958	0	136,958	8.00
9.00	00900	HOUSEKEEPING	404,542	205,361	609,903	0	609,903	9.00
10.00	01000	DIETARY	0	1,000,837	1,000,837	-732,414	268,423	10.00
11.00	01100	CAFETERIA	0	0	0	732,414	732,414	11.00
13.00	01300	NURSING ADMINISTRATION	1,034,302	314,948	1,349,250	93,183	1,442,433	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	86,651	2,250,892	2,337,543	-2,047,880	289,663	14.00
15.00	01500	PHARMACY	545,976	1,161,607	1,707,583	-909,894	797,689	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	301,254	238,542	539,796	0	539,796	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,765,699	1,374,455	3,140,154	987,850	4,128,004	30.00
31.00	03100	INTENSIVE CARE UNIT	1,017,854	271,688	1,289,542	-1,233	1,288,309	31.00
40.00	04000	SUBPROVIDER - IPF	1,222,514	612,894	1,835,408	-1,954	1,833,454	40.00
43.00	04300	NURSERY	0	604	604	517,422	518,026	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,136,208	950,311	2,086,519	240,496	2,327,015	50.00
51.00	05100	RECOVERY ROOM	254,879	31,998	286,877	-286,877	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,069,034	867,658	1,936,692	-1,507,798	428,894	52.00
53.00	05300	ANESTHESIOLOGY	0	1,729,683	1,729,683	0	1,729,683	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	550,815	912,302	1,463,117	803,948	2,267,065	54.00
54.01	05401	ULTRASOUND	98,753	37,417	136,170	-136,170	0	54.01
56.00	05600	RADIOISOTOPE	46,990	305,272	352,262	-352,262	0	56.00
57.00	05700	CT SCAN	116,297	248,150	364,447	-364,447	0	57.00
58.00	05800	MRI	87,780	123,247	211,027	-211,027	0	58.00
60.00	06000	LABORATORY	894,537	1,303,921	2,198,458	-27,257	2,171,201	60.00
65.00	06500	RESPIRATORY THERAPY	286,963	108,613	395,576	62,206	457,782	65.00
66.00	06600	PHYSICAL THERAPY	0	382,081	382,081	243,509	625,590	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	98,445	98,445	-98,445	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	145,064	145,064	-145,064	0	68.00
69.00	06900	ELECTROCARDIOLOGY	395,682	284,773	680,455	-13,205	667,250	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	921,944	921,944	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,107,547	1,107,547	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	848,622	848,622	73.00
74.00	07400	RENAL DIALYSIS	0	160,036	160,036	0	160,036	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	63,002	11,055	74,057	-74,057	0	76.01
76.03	03950	WOUND CARE	113,401	610,446	723,847	-491	723,356	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	908,865	1,588,348	2,497,213	1,308,659	3,805,872	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	71,512	1,239,184	1,310,696	-1,310,696	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,125,792	38,224,668	53,350,460	-226,367	53,124,093	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,564	68,234	95,798	0	95,798	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	226,367	226,367	194.01
194.02	07952	SENIOR CIRCLE	0	28,218	28,218	0	28,218	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	15,153,356	38,321,120	53,474,476	0	53,474,476	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet A

Date/Time Prepared:
9/30/2019 10:39 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-186,680	1,756,068	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-327,974	1,827,957	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,422	2,827,566	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,266,499	6,740,868	5.00
7.00	00700	OPERATION OF PLANT	-16,746	2,340,384	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	136,958	8.00
9.00	00900	HOUSEKEEPING	0	609,903	9.00
10.00	01000	DIETARY	0	268,423	10.00
11.00	01100	CAFETERIA	0	732,414	11.00
13.00	01300	NURSING ADMINISTRATION	-2,516	1,439,917	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	289,663	14.00
15.00	01500	PHARMACY	0	797,689	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-416	539,380	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,025,317	3,102,687	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,288,309	31.00
40.00	04000	SUBPROVIDER - IPF	-404,662	1,428,792	40.00
43.00	04300	NURSERY	-97,933	420,093	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,327,015	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-81,113	347,781	52.00
53.00	05300	ANESTHESIOLOGY	-1,683,265	46,418	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,267,065	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	-90,000	2,081,201	60.00
65.00	06500	RESPIRATORY THERAPY	-400	457,382	65.00
66.00	06600	PHYSICAL THERAPY	0	625,590	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	667,250	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	921,944	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,107,547	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-112	848,510	73.00
74.00	07400	RENAL DIALYSIS	0	160,036	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.03	03950	WOUND CARE	0	723,356	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-2,117,479	1,688,393	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-12,307,534	40,816,559	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	95,798	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	MARKETING	0	226,367	194.01
194.02	07952	SENIOR CIRCLE	0	28,218	194.02
194.03	07953	UNUSED SPACE	0	0	194.03
194.04	07954	GUEST MEALS	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-12,307,534	41,166,942	200.00

RECLASSIFICATIONS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet A-6
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,626,874		1.00
2.00		0.00	0	0		2.00
	0		0	2,626,874		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	109,749		1.00
	0		0	109,749		
	C - RENTAL AND LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	453,624		1.00
2.00	RADIOISOTOPE	56.00	0	27,948		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
	0		0	481,572		
	D - OTHER CAP COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	51,322		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	489,649		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,543		3.00
	0		0	543,514		
	E - MARKETING DEPT					
1.00	MARKETING	194.01	88,085	138,282		1.00
	0		88,085	138,282		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	812,195		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,107,547		2.00
	0		0	1,919,742		
	G - COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	848,622		1.00
	0		0	848,622		
	H - LABOR AND DELIV					
1.00	ADULTS & PEDIATRICS	30.00	546,093	443,679		1.00
2.00	NURSERY	43.00	285,809	231,613		2.00
	0		831,902	675,292		
	I - THERAPY COSTS					
1.00	PHYSICAL THERAPY	66.00	0	243,509		1.00
2.00		0.00	0	0		2.00
	0		0	243,509		
	J - MISCELLANEOUS DEPTS					
1.00	NURSING ADMINISTRATION	13.00	63,284	30,351		1.00
2.00	OPERATING ROOM	50.00	254,879	31,291		2.00
3.00	RESPIRATORY THERAPY	65.00	63,002	11,055		3.00
4.00	EMERGENCY	91.00	71,512	1,239,184		4.00
	0		452,677	1,311,881		
	K - OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	349,820	643,833		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		349,820	643,833		
	L - DIETARY TO CAFETERIA					
1.00	CAFETERIA	11.00	0	732,414		1.00
	0		0	732,414		
500.00	Grand Total: Increases		1,722,484	10,275,284		500.00

RECLASSIFICATIONS

Provider CCN: 14-0040

Period:
From 05/01/2018
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Worksheet A-6

Date/Time Prepared:
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Decreases						wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
A - EMPLOYEE BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	322	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	2,626,552	0		2.00
	0		0	2,626,874			
B - OXYGEN COSTS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	109,749	0		1.00
	0		0	109,749			
C - RENTAL AND LEASE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,618	10		1.00
2.00	NURSING ADMINISTRATION	13.00	0	452	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	18,389	0		3.00
4.00	PHARMACY	15.00	0	61,272	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	1,922	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	1,233	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	1,954	0		7.00
8.00	OPERATING ROOM	50.00	0	45,674	0		8.00
9.00	RECOVERY ROOM	51.00	0	707	0		9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0	604	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	189,705	0		11.00
12.00	CT SCAN	57.00	0	97,503	0		12.00
13.00	MRI	58.00	0	698	0		13.00
14.00	LABORATORY	60.00	0	27,257	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	11,851	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	13,205	0		16.00
17.00	WOUND CARE	76.03	0	491	0		17.00
18.00	EMERGENCY	91.00	0	2,037	0		18.00
	0		0	481,572			
D - OTHER CAP COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	543,514	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	543,514			
E - MARKETING DEPT							
1.00	ADMINISTRATIVE & GENERAL	5.00	88,085	138,282	0		1.00
	0		88,085	138,282			
F - MEDICAL SUPPLIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,919,742	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	1,919,742			
G - COST OF DRUGS/IV SOLUTIONS							
1.00	PHARMACY	15.00	0	848,622	0		1.00
	0		0	848,622			
H - LABOR AND DELIV							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	831,902	675,292	0		1.00
2.00		0.00	0	0	0		2.00
	0		831,902	675,292			
I - THERAPY COSTS							
1.00	OCCUPATIONAL THERAPY	67.00	0	98,445	0		1.00
2.00	SPEECH PATHOLOGY	68.00	0	145,064	0		2.00
	0		0	243,509			
J - MISCELLANEOUS DEPTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	63,284	30,351	0		1.00
2.00	RECOVERY ROOM	51.00	254,879	31,291	0		2.00
3.00	SLEEP LAB	76.01	63,002	11,055	0		3.00
4.00	AMBULANCE SERVICES	95.00	71,512	1,239,184	0		4.00
	0		452,677	1,311,881			
K - OTHER RADIOLOGY COSTS							
1.00	ULTRASOUND	54.01	98,753	37,417	0		1.00
2.00	RADIOISOTOPE	56.00	46,990	333,220	0		2.00
3.00	CT SCAN	57.00	116,297	150,647	0		3.00
4.00	MRI	58.00	87,780	122,549	0		4.00
	0		349,820	643,833			
L - DIETARY TO CAFETERIA							
1.00	DIETARY	10.00	0	732,414	0		1.00
	0		0	732,414			
500.00	Grand Total: Decreases		1,722,484	10,275,284			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part I
Date/Time Prepared:
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		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	259,268	0	0	0	244,043	1.00	
2.00	Land Improvements	554,380	0	0	0	421,916	2.00	
3.00	Buildings and Fixtures	15,726,371	3,468	0	3,468	9,803,979	3.00	
4.00	Building Improvements	15,119,693	255,088	0	255,088	84,926	4.00	
5.00	Fixed Equipment	4,144,383	144,944	0	144,944	19,248	5.00	
6.00	Movable Equipment	17,277,151	11,922,292	0	11,922,292	12,202,604	6.00	
7.00	HIT designated Assets	4,746,629	10,885	0	10,885	33,575	7.00	
8.00	Subtotal (sum of lines 1-7)	57,827,875	12,336,677	0	12,336,677	22,810,291	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	57,827,875	12,336,677	0	12,336,677	22,810,291	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	15,225	0				1.00	
2.00	Land Improvements	132,464	0				2.00	
3.00	Buildings and Fixtures	5,925,860	0				3.00	
4.00	Building Improvements	15,289,855	0				4.00	
5.00	Fixed Equipment	4,270,079	0				5.00	
6.00	Movable Equipment	16,996,839	0				6.00	
7.00	HIT designated Assets	4,723,939	0				7.00	
8.00	Subtotal (sum of lines 1-7)	47,354,261	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	47,354,261	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,480,177	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,699,236	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,179,413	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	-78,400	1,401,777				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	528	1,699,764				2.00
3.00	Total (sum of lines 1-2)	-77,872	3,101,541				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part III
Date/Time Prepared:
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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	21,363,405	0	21,363,405	0.451140	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	25,990,857	0	25,990,857	0.548860	0	2.00
3.00	Total (sum of lines 1-2)	47,354,262	0	47,354,262	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	1,223,768	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,371,262	453,624	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,595,030	453,624	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	51,322	489,649	-8,671	1,756,068	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,543	0	528	1,827,957	2.00
3.00	Total (sum of lines 1-2)	0	53,865	489,649	-8,143	3,584,025	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8

Date/Time Prepared:
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Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-22,336	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,233	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,502,685			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-2,091,344			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	0	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-8,671	CAP REL COSTS-BLDG & FIXT	1.00	14	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	B	-112	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-416	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-2,366	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-354,067	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-329,665	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LOBBYING EXPENSES	A	-8,250	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8

Date/Time Prepared:
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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	
36.00	OTHER MISCELLANEOUS REVENUE	B	-15,371	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	DEPRECIATION - ADMIN AND GENERAL	A	-102,334	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PATIENT PHONE WAGE COST	A	-25,429	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	PATIENT PHONES BENEFITS COST	A	-6,422	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	PATIENT PHONES DEPRECIATION COST	A	-14,335	CAP REL COSTS-MVBLE EQUIP	2.00	9	41.00
42.00	PATIENT TV CABLE EXPENSE	A	-16,746	OPERATION OF PLANT	7.00	0	42.00
43.00	MARKETING EXP - EXCL MARKETING DEPT	A	-225,650	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	ILLINOIS PROVIDER TAX	A	-3,575,552	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	PHYSICIAN RECRUITING	A	-44,056	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-4,149	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	47.00
48.00	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	48.00
49.00	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	49.00
49.01	MINORITY INTEREST	A	78,400	CAP REL COSTS-BLDG & FIXT	1.00	14	49.01
49.02	NONALLOWABLE LEGAL FEES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	49.02
49.03	TELEPHONE COMMISSIONS	B	-3,000	ADMINISTRATIVE & GENERAL	5.00	0	49.03
49.04	HELATHY WOMEN SPONSORSHIP	B	-23,745	ADMINISTRATIVE & GENERAL	5.00	0	49.04
49.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,307,534				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8-1

Date/Time Prepared:
9/30/2019 10:39 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	0.00			0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	408,653	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	97,658	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	25,259	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	923,912	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	41,617	702,914	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	2,885,529	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
4.06	0.00			0	0	4.06
4.07	0.00			0	0	4.07
4.08	0.00			0	0	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
4.11	0.00			0	0	4.11
4.12	0.00			0	0	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
4.17	0.00			0	0	4.17
4.20	0.00			0	0	4.20
4.21	0.00			0	0	4.21
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,497,099	3,588,443	5.00

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

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

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

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

6.00	B	QUORUM HEALTH C	100.00	QHC	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8-1

Date/Time Prepared:
9/30/2019 10:39 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

1.00	0	0		1.00
2.00	408,653	0		2.00
3.00	97,658	9		3.00
4.00	25,259	9		4.00
4.01	923,912	0		4.01
4.02	-661,297	0		4.02
4.03	-2,885,529	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.17	0	0		4.17
4.20	0	0		4.20
4.21	0	0		4.21
5.00	-2,091,344			5.00

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

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

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

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

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

6.00	HOSPITAL CORP		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8-2

Date/Time Prepared:
9/30/2019 10:39 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	13.00	NURSING ADMINISTRATION	14,300	0	14,300	171,400	143	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,025,317	1,025,317	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	404,662	404,662	0	0	0	3.00
4.00	43.00	NURSERY	97,933	97,933	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	81,113	81,113	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	1,683,265	1,683,265	0	0	0	6.00
7.00	60.00	LABORATORY	90,000	90,000	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	400	400	0	0	0	8.00
9.00	91.00	EMERGENCY	2,117,479	2,117,479	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,514,469	5,500,169	14,300		143	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	13.00	NURSING ADMINISTRATION	11,784	589	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	43.00	NURSERY	0	0	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			11,784	589	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	13.00	NURSING ADMINISTRATION	0	11,784	2,516	2,516		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,025,317		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	404,662		3.00
4.00	43.00	NURSERY	0	0	0	97,933		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	81,113		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	1,683,265		6.00
7.00	60.00	LABORATORY	0	0	0	90,000		7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	400		8.00
9.00	91.00	EMERGENCY	0	0	0	2,117,479		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	11,784	2,516	5,502,685		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
9/30/2019 10:39 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,756,068	1,756,068				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,827,957		1,827,957			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,827,566	6,141	6,393	2,840,100		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,740,868	229,406	238,797	366,707	7,575,778	5.00
7.00	00700	OPERATION OF PLANT	2,340,384	521,434	542,779	83,124	3,487,721	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	136,958	13,001	13,533	0	163,492	8.00
9.00	00900	HOUSEKEEPING	609,903	18,678	19,443	76,425	724,449	9.00
10.00	01000	DIETARY	268,423	47,507	49,452	0	365,382	10.00
11.00	01100	CAFETERIA	732,414	23,146	24,094	0	779,654	11.00
13.00	01300	NURSING ADMINISTRATION	1,439,917	25,808	26,865	207,353	1,699,943	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	289,663	50,843	52,924	16,370	409,800	14.00
15.00	01500	PHARMACY	797,689	18,739	19,506	103,144	939,078	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	539,380	52,036	54,166	56,912	702,494	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,102,687	181,325	188,748	436,745	3,909,505	30.00
31.00	03100	INTENSIVE CARE UNIT	1,288,309	29,619	30,831	192,290	1,541,049	31.00
40.00	04000	SUBPROVIDER - IPF	1,428,792	54,190	56,408	230,954	1,770,344	40.00
43.00	04300	NURSERY	420,093	7,721	8,037	53,994	489,845	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,327,015	105,292	109,603	262,800	2,804,710	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	347,781	0	0	44,798	392,579	52.00
53.00	05300	ANESTHESIOLOGY	46,418	2,364	2,461	0	51,243	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,267,065	70,951	73,856	170,145	2,582,017	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,081,201	46,093	47,980	168,993	2,344,267	60.00
65.00	06500	RESPIRATORY THERAPY	457,382	18,181	18,925	66,114	560,602	65.00
66.00	06600	PHYSICAL THERAPY	625,590	21,804	22,697	0	670,091	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	667,250	45,442	47,302	74,751	834,745	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	921,944	0	0	0	921,944	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,107,547	0	0	0	1,107,547	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	848,510	0	0	0	848,510	73.00
74.00	07400	RENAL DIALYSIS	160,036	0	0	0	160,036	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	723,356	28,614	29,785	21,423	803,178	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,688,393	34,368	35,775	185,210	1,943,746	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,816,559	1,652,703	1,720,360	2,818,252	40,583,749	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	95,798	16,154	16,816	5,207	133,975	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,131	5,341	0	10,472	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	226,367	0	0	16,641	243,008	194.01
194.02	07952	SENIOR CIRCLE	28,218	0	0	0	28,218	194.02
194.03	07953	UNUSED SPACE	0	82,080	85,440	0	167,520	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	41,166,942	1,756,068	1,827,957	2,840,100	41,166,942	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
9/30/2019 10:39 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
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	7,575,778					5.00
7.00	00700	OPERATION OF PLANT	786,582	4,274,303				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,872	55,620	255,984			8.00
9.00	00900	HOUSEKEEPING	163,384	79,909	0	967,742		9.00
10.00	01000	DIETARY	82,404	203,246	0	51,930	702,962	10.00
11.00	01100	CAFETERIA	175,835	99,024	0	25,301	0	11.00
13.00	01300	NURSING ADMINISTRATION	383,386	110,412	0	28,211	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	92,422	217,517	3,144	55,576	0	14.00
15.00	01500	PHARMACY	211,789	80,169	0	20,483	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	158,433	222,620	0	56,880	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	881,704	775,747	84,551	198,202	276,256	30.00
31.00	03100	INTENSIVE CARE UNIT	347,551	126,715	23,356	32,376	69,207	31.00
40.00	04000	SUBPROVIDER - IPF	399,264	231,835	23,694	59,234	251,306	40.00
43.00	04300	NURSERY	110,474	33,032	0	8,440	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	632,543	450,463	33,199	115,094	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	88,538	0	0	0	57,127	52.00
53.00	05300	ANESTHESIOLOGY	11,557	10,113	0	2,584	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	582,320	303,545	21,594	77,556	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	528,700	197,197	1,123	50,384	0	60.00
65.00	06500	RESPIRATORY THERAPY	126,432	77,782	194	19,874	0	65.00
66.00	06600	PHYSICAL THERAPY	151,125	93,282	0	23,834	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	188,259	194,409	3,250	49,672	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	207,925	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	249,784	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	191,364	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	36,093	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	181,140	122,415	7,593	31,277	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	438,371	147,035	47,067	37,568	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,444,251	3,832,087	248,765	944,476	653,896	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,215	69,111	0	17,658	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,362	21,950	7,219	5,608	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	54,805	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	6,364	0	0	0	33,516	194.02
194.03	07953	UNUSED SPACE	37,781	351,155	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	15,550	194.04
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)	7,575,778	4,274,303	255,984	967,742	702,962	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	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						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,079,814					11.00
13.00	01300	NURSING ADMINISTRATION	78,790	2,300,742				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,557	0	794,016			14.00
15.00	01500	PHARMACY	34,516	0	4,019	1,290,054		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	39,813	0	1,786	0	1,182,026	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	201,300	714,267	23,952	0	77,344	30.00
31.00	03100	INTENSIVE CARE UNIT	88,604	314,483	16,434	0	22,017	31.00
40.00	04000	SUBPROVIDER - IPF	120,779	377,716	7,217	0	49,079	40.00
43.00	04300	NURSERY	19,962	88,306	130	0	6,692	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	110,128	429,800	114,479	0	226,792	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,617	73,266	24,204	0	5,543	52.00
53.00	05300	ANESTHESIOLOGY	0	0	7,929	0	66,921	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,013	0	18,979	0	182,875	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	113,474	0	90,284	0	229,401	60.00
65.00	06500	RESPIRATORY THERAPY	35,018	0	8,946	0	21,094	65.00
66.00	06600	PHYSICAL THERAPY	0	0	115	0	11,038	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	32,843	0	182	0	48,168	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	166,111	0	16,461	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	267,398	0	48,520	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,290,054	26,841	73.00
74.00	07400	RENAL DIALYSIS	0	0	73	0	2,644	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	10,149	0	11,425	0	20,691	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	72,991	302,904	29,822	0	119,905	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,069,554	2,300,742	793,485	1,290,054	1,182,026	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,684	0	36	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	5,576	0	375	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	120	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,079,814	2,300,742	794,016	1,290,054	1,182,026	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,142,828	0	7,142,828	30.00
31.00	03100	INTENSIVE CARE UNIT	2,581,792	0	2,581,792	31.00
40.00	04000	SUBPROVIDER - IPF	3,290,468	0	3,290,468	40.00
43.00	04300	NURSERY	756,881	0	756,881	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,917,208	0	4,917,208	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	657,874	0	657,874	52.00
53.00	05300	ANESTHESIOLOGY	150,347	0	150,347	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,847,899	0	3,847,899	54.00
54.01	05401	ULTRASOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	3,554,830	0	3,554,830	60.00
65.00	06500	RESPIRATORY THERAPY	849,942	0	849,942	65.00
66.00	06600	PHYSICAL THERAPY	949,485	0	949,485	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,351,528	0	1,351,528	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,312,441	0	1,312,441	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,673,249	0	1,673,249	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,356,769	0	2,356,769	73.00
74.00	07400	RENAL DIALYSIS	198,846	0	198,846	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	76.01
76.03	03950	WOUND CARE	1,187,868	0	1,187,868	76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,139,409	0	3,139,409	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	95.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,919,664	0	39,919,664	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	255,679	0	255,679	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,611	0	47,611	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01	07951	MARKETING	303,764	0	303,764	194.01
194.02	07952	SENIOR CIRCLE	68,218	0	68,218	194.02
194.03	07953	UNUSED SPACE	556,456	0	556,456	194.03
194.04	07954	GUEST MEALS	15,550	0	15,550	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	41,166,942	0	41,166,942	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
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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	6,141	6,393	12,534	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	229,406	238,797	468,203	5.00
7.00	00700	OPERATION OF PLANT	0	521,434	542,779	1,064,213	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,001	13,533	26,534	8.00
9.00	00900	HOUSEKEEPING	0	18,678	19,443	38,121	9.00
10.00	01000	DIETARY	0	47,507	49,452	96,959	10.00
11.00	01100	CAFETERIA	0	23,146	24,094	47,240	11.00
13.00	01300	NURSING ADMINISTRATION	0	25,808	26,865	52,673	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	50,843	52,924	103,767	14.00
15.00	01500	PHARMACY	0	18,739	19,506	38,245	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	52,036	54,166	106,202	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	181,325	188,748	370,073	30.00
31.00	03100	INTENSIVE CARE UNIT	0	29,619	30,831	60,450	31.00
40.00	04000	SUBPROVIDER - IPF	0	54,190	56,408	110,598	40.00
43.00	04300	NURSERY	0	7,721	8,037	15,758	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	105,292	109,603	214,895	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	198	52.00
53.00	05300	ANESTHESIOLOGY	0	2,364	2,461	4,825	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	70,951	73,856	144,807	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	46,093	47,980	94,073	60.00
65.00	06500	RESPIRATORY THERAPY	0	18,181	18,925	37,106	65.00
66.00	06600	PHYSICAL THERAPY	0	21,804	22,697	44,501	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	45,442	47,302	92,744	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	28,614	29,785	58,399	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	34,368	35,775	70,143	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	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,652,703	1,720,360	3,373,063	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,154	16,816	32,970	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,131	5,341	10,472	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	82,080	85,440	167,520	194.03
194.04	07954	GUEST MEALS	0	0	0	0	194.04
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	1,756,068	1,827,957	3,584,025	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
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	469,822					5.00
7.00	00700	OPERATION OF PLANT	48,779	1,113,359				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,287	14,488	43,309			8.00
9.00	00900	HOUSEKEEPING	10,132	20,814	0	69,404		9.00
10.00	01000	DIETARY	5,110	52,941	0	3,724	158,734	10.00
11.00	01100	CAFETERIA	10,904	25,793	0	1,815	0	11.00
13.00	01300	NURSING ADMINISTRATION	23,775	28,760	0	2,023	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,731	56,658	532	3,986	0	14.00
15.00	01500	PHARMACY	13,134	20,882	0	1,469	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,825	57,988	0	4,079	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	54,695	202,064	14,305	14,218	62,381	30.00
31.00	03100	INTENSIVE CARE UNIT	21,553	33,007	3,951	2,322	15,627	31.00
40.00	04000	SUBPROVIDER - IPF	24,760	60,388	4,009	4,248	56,747	40.00
43.00	04300	NURSERY	6,851	8,604	0	605	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	39,227	117,335	5,617	8,254	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,491	0	0	0	12,900	52.00
53.00	05300	ANESTHESIOLOGY	717	2,634	0	185	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,112	79,067	3,653	5,562	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	32,787	51,365	190	3,613	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,841	20,261	33	1,425	0	65.00
66.00	06600	PHYSICAL THERAPY	9,372	24,298	0	1,709	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	11,675	50,639	550	3,562	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,894	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,490	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,867	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,238	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	11,233	31,886	1,285	2,243	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	27,185	38,299	7,963	2,694	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	461,665	998,171	42,088	67,736	147,655	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,874	18,002	0	1,266	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	146	5,718	1,221	402	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	3,399	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	395	0	0	0	7,568	194.02
194.03	07953	UNUSED SPACE	2,343	91,468	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	3,511	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	469,822	1,113,359	43,309	69,404	158,734	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
9/30/2019 10:39 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	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						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	85,752					11.00
13.00	01300	NURSING ADMINISTRATION	6,257	114,403				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,235	0	171,981			14.00
15.00	01500	PHARMACY	2,741	0	871	77,797		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,162	0	387	0	181,894	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,986	35,518	5,188	0	11,894	30.00
31.00	03100	INTENSIVE CARE UNIT	7,036	15,637	3,560	0	3,386	31.00
40.00	04000	SUBPROVIDER - IPF	9,591	18,781	1,563	0	7,547	40.00
43.00	04300	NURSERY	1,585	4,391	28	0	1,029	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,746	21,371	24,796	0	34,875	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,320	3,643	5,243	0	852	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,717	0	10,291	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,275	0	4,111	0	28,122	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	9,011	0	19,555	0	35,403	60.00
65.00	06500	RESPIRATORY THERAPY	2,781	0	1,938	0	3,244	65.00
66.00	06600	PHYSICAL THERAPY	0	0	25	0	1,697	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	2,608	0	39	0	7,407	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	35,979	0	2,531	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	57,916	0	7,461	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	77,797	4,127	73.00
74.00	07400	RENAL DIALYSIS	0	0	16	0	407	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	806	0	2,475	0	3,182	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,797	15,062	6,459	0	18,439	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,937	114,403	171,866	77,797	181,894	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	372	0	8	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	443	0	81	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	26	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
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)	85,752	114,403	171,981	77,797	181,894	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
9/30/2019 10:39 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	788,247	0	788,247	30.00
31.00	03100	INTENSIVE CARE UNIT	167,378	0	167,378	31.00
40.00	04000	SUBPROVIDER - IPF	299,252	0	299,252	40.00
43.00	04300	NURSERY	39,089	0	39,089	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	476,276	0	476,276	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,647	0	29,647	52.00
53.00	05300	ANESTHESIOLOGY	20,369	0	20,369	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,460	0	308,460	54.00
54.01	05401	ULTRASOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	246,743	0	246,743	60.00
65.00	06500	RESPIRATORY THERAPY	74,921	0	74,921	65.00
66.00	06600	PHYSICAL THERAPY	81,602	0	81,602	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	169,554	0	169,554	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,404	0	51,404	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,867	0	80,867	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	93,791	0	93,791	73.00
74.00	07400	RENAL DIALYSIS	2,661	0	2,661	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	76.01
76.03	03950	WOUND CARE	111,604	0	111,604	76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	192,859	0	192,859	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	95.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,234,724	0	3,234,724	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	54,515	0	54,515	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,959	0	17,959	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01	07951	MARKETING	3,996	0	3,996	194.01
194.02	07952	SENIOR CIRCLE	7,989	0	7,989	194.02
194.03	07953	UNUSED SPACE	261,331	0	261,331	194.03
194.04	07954	GUEST MEALS	3,511	0	3,511	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,584,025	0	3,584,025	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
9/30/2019 10:39 am

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	317,967				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		317,967			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,112	1,112	15,033,548		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	41,538	41,538	1,941,101	-7,575,778	5.00
7.00	00700	OPERATION OF PLANT	94,415	94,415	440,004	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,354	2,354	0	0	8.00
9.00	00900	HOUSEKEEPING	3,382	3,382	404,542	0	9.00
10.00	01000	DIETARY	8,602	8,602	0	0	10.00
11.00	01100	CAFETERIA	4,191	4,191	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,673	4,673	1,097,586	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,206	9,206	86,651	0	14.00
15.00	01500	PHARMACY	3,393	3,393	545,976	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,422	9,422	301,254	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	32,832	32,832	2,311,792	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,363	5,363	1,017,854	0	31.00
40.00	04000	SUBPROVIDER - IPF	9,812	9,812	1,222,514	0	40.00
43.00	04300	NURSERY	1,398	1,398	285,809	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,065	19,065	1,391,087	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	237,132	0	52.00
53.00	05300	ANESTHESIOLOGY	428	428	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,847	12,847	900,635	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	8,346	8,346	894,537	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,292	3,292	349,965	0	65.00
66.00	06600	PHYSICAL THERAPY	3,948	3,948	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	8,228	8,228	395,682	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03950	WOUND CARE	5,181	5,181	113,401	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	6,223	6,223	980,377	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	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	299,251	299,251	14,917,899	-7,575,778	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,925	2,925	27,564	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	929	929	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	88,085	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	14,862	14,862	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,756,068	1,827,957	2,840,100	7,575,778	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.522800	5.748889	0.188917	0.225529	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,534	469,822	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000834	0.013986	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
9/30/2019 10:39 am

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	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:

9/30/2019 10:39 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
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	180,902				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,354	358,496			8.00
9.00	00900	HOUSEKEEPING	3,382	0	160,304		9.00
10.00	01000	DIETARY	8,602	0	8,602	32,006	10.00
11.00	01100	CAFETERIA	4,191	0	4,191	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,673	0	4,673	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,206	4,403	9,206	0	14.00
15.00	01500	PHARMACY	3,393	0	3,393	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,422	0	9,422	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	32,832	118,411	32,832	12,578	30.00
31.00	03100	INTENSIVE CARE UNIT	5,363	32,709	5,363	3,151	31.00
40.00	04000	SUBPROVIDER - IPF	9,812	33,182	9,812	11,442	40.00
43.00	04300	NURSERY	1,398	0	1,398	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,065	46,494	19,065	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,601	52.00
53.00	05300	ANESTHESIOLOGY	428	0	428	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,847	30,242	12,847	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	8,346	1,573	8,346	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,292	271	3,292	0	65.00
66.00	06600	PHYSICAL THERAPY	3,948	0	3,948	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	8,228	4,551	8,228	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03950	WOUND CARE	5,181	10,634	5,181	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	6,223	65,916	6,223	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	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	162,186	348,386	156,450	29,772	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,925	0	2,925	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	929	10,110	929	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	1,526	194.02
194.03	07953	UNUSED SPACE	14,862	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	708	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,274,303	255,984	967,742	702,962	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.627727	0.714050	6.036917	21.963444	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,113,359	43,309	69,404	158,734	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.154487	0.120807	0.432952	4.959508	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: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
9/30/2019 10:39 am

Cost Center Description			NURSING ADMINISTRATION (NURSING WA GES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			13.00	14.00	15.00	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					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	7,446,564				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,682,814			14.00
15.00	01500	PHARMACY	0	18,643	867,265		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,283	0	352,952,408	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,311,792	111,093	0	23,094,694	30.00
31.00	03100	INTENSIVE CARE UNIT	1,017,854	76,225	0	6,574,244	31.00
40.00	04000	SUBPROVIDER - IPF	1,222,514	33,475	0	14,654,915	40.00
43.00	04300	NURSERY	285,809	604	0	1,998,218	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,391,086	530,977	0	67,719,315	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	237,132	112,265	0	1,655,021	52.00
53.00	05300	ANESTHESIOLOGY	0	36,776	0	19,982,296	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	88,029	0	54,605,867	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	418,759	0	68,501,262	60.00
65.00	06500	RESPIRATORY THERAPY	0	41,494	0	6,298,620	65.00
66.00	06600	PHYSICAL THERAPY	0	533	0	3,296,027	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	843	0	14,382,903	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	770,461	0	4,915,335	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,240,235	0	14,487,951	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	867,265	8,014,535	73.00
74.00	07400	RENAL DIALYSIS	0	338	0	789,588	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	52,992	0	6,178,304	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	980,377	138,323	0	35,803,313	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	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,446,564	3,680,348	867,265	352,952,408	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	168	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,741	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	557	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	194.04
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)	2,300,742	794,016	1,290,054	1,182,026	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.308967	0.215600	1.487497	0.003349	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	114,403	171,981	77,797	181,894	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.015363	0.046698	0.089704	0.000515	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0040	Period: From 05/01/2018 To 04/30/2019	Worksheet C Part I Date/Time Prepared: 9/30/2019 10:39 am	
					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	7,142,828		7,142,828	0	7,142,828	30.00
31.00	03100	INTENSIVE CARE UNIT	2,581,792		2,581,792	0	2,581,792	31.00
40.00	04000	SUBPROVIDER - IPF	3,290,468		3,290,468	0	3,290,468	40.00
43.00	04300	NURSERY	756,881		756,881	0	756,881	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,917,208		4,917,208	0	4,917,208	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	657,874		657,874	0	657,874	52.00
53.00	05300	ANESTHESIOLOGY	150,347		150,347	0	150,347	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,847,899		3,847,899	0	3,847,899	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,554,830		3,554,830	0	3,554,830	60.00
65.00	06500	RESPIRATORY THERAPY	849,942	0	849,942	0	849,942	65.00
66.00	06600	PHYSICAL THERAPY	949,485	0	949,485	0	949,485	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	1,351,528		1,351,528	0	1,351,528	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,312,441		1,312,441	0	1,312,441	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,673,249		1,673,249	0	1,673,249	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,356,769		2,356,769	0	2,356,769	73.00
74.00	07400	RENAL DIALYSIS	198,846		198,846	0	198,846	74.00
76.00	03560	OTHER ANCILLARY COSTS	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03950	WOUND CARE	1,187,868		1,187,868	0	1,187,868	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,139,409		3,139,409	0	3,139,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	971,973		971,973	0	971,973	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	40,891,637	0	40,891,637	0	40,891,637	200.00
201.00		Less Observation Beds	971,973		971,973	0	971,973	201.00
202.00		Total (see instructions)	39,919,664	0	39,919,664	0	39,919,664	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
9/30/2019 10:39 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,830,621		18,830,621		30.00
31.00	03100	INTENSIVE CARE UNIT	6,574,244		6,574,244		31.00
40.00	04000	SUBPROVIDER - IPF	14,654,915		14,654,915		40.00
43.00	04300	NURSERY	1,998,218		1,998,218		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,453,253	47,266,062	67,719,315	0.072612	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,570,847	84,174	1,655,021	0.397502	0.000000
53.00	05300	ANESTHESIOLOGY	7,001,842	12,980,454	19,982,296	0.007524	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,054,969	45,550,898	54,605,867	0.070467	0.000000
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000
58.00	05800	MRI	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	16,136,418	52,364,844	68,501,262	0.051894	0.000000
65.00	06500	RESPIRATORY THERAPY	4,227,854	2,070,766	6,298,620	0.134941	0.000000
66.00	06600	PHYSICAL THERAPY	3,018,286	277,741	3,296,027	0.288070	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000
69.00	06900	ELECTROCARDIOLOGY	3,214,717	11,168,186	14,382,903	0.093968	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,853,743	2,061,592	4,915,335	0.267009	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,969,221	6,518,730	14,487,951	0.115492	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	4,281,006	3,733,529	8,014,535	0.294062	0.000000
74.00	07400	RENAL DIALYSIS	700,408	89,180	789,588	0.251835	0.000000
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000
76.03	03950	WOUND CARE	8,150	6,170,154	6,178,304	0.192264	0.000000
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,368,049	30,435,264	35,803,313	0.087685	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,224,420	3,039,653	4,264,073	0.227945	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000
200.00		Subtotal (see instructions)	129,141,181	223,811,227	352,952,408		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	129,141,181	223,811,227	352,952,408		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0040	Period: From 05/01/2018 To 04/30/2019	Worksheet C Part I Date/Time Prepared: 9/30/2019 10:39 am
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.072612		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.397502		52.00
53.00	05300	ANESTHESIOLOGY	0.007524		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.070467		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.051894		60.00
65.00	06500	RESPIRATORY THERAPY	0.134941		65.00
66.00	06600	PHYSICAL THERAPY	0.288070		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.093968		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.267009		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.115492		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294062		73.00
74.00	07400	RENAL DIALYSIS	0.251835		74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.03	03950	WOUND CARE	0.192264		76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.087685		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.227945		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
9/30/2019 10:39 am

			Title XIX		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	7,142,828		7,142,828	0	7,142,828	30.00
31.00	03100	INTENSIVE CARE UNIT	2,581,792		2,581,792	0	2,581,792	31.00
40.00	04000	SUBPROVIDER - IPF	3,290,468		3,290,468	0	3,290,468	40.00
43.00	04300	NURSERY	756,881		756,881	0	756,881	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,917,208		4,917,208	0	4,917,208	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	657,874		657,874	0	657,874	52.00
53.00	05300	ANESTHESIOLOGY	150,347		150,347	0	150,347	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,847,899		3,847,899	0	3,847,899	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,554,830		3,554,830	0	3,554,830	60.00
65.00	06500	RESPIRATORY THERAPY	849,942	0	849,942	0	849,942	65.00
66.00	06600	PHYSICAL THERAPY	949,485	0	949,485	0	949,485	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	1,351,528		1,351,528	0	1,351,528	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,312,441		1,312,441	0	1,312,441	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,673,249		1,673,249	0	1,673,249	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,356,769		2,356,769	0	2,356,769	73.00
74.00	07400	RENAL DIALYSIS	198,846		198,846	0	198,846	74.00
76.00	03560	OTHER ANCILLARY COSTS	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03950	WOUND CARE	1,187,868		1,187,868	0	1,187,868	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,139,409		3,139,409	0	3,139,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	971,973		971,973		971,973	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	40,891,637	0	40,891,637	0	40,891,637	200.00
201.00		Less Observation Beds	971,973		971,973		971,973	201.00
202.00		Total (see instructions)	39,919,664	0	39,919,664	0	39,919,664	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0040		Period: From 05/01/2018 To 04/30/2019		Worksheet C Part I Date/Time Prepared: 9/30/2019 10:39 am		
					Title XIX			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio				
			Inpatient	Outpatient	Total (col. 6 + col. 7)						
			6.00	7.00	8.00				9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	18,830,621		18,830,621					30.00	
31.00	03100	INTENSIVE CARE UNIT	6,574,244		6,574,244					31.00	
40.00	04000	SUBPROVIDER - IPF	14,654,915		14,654,915					40.00	
43.00	04300	NURSERY	1,998,218		1,998,218					43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0					44.00	
ANCILLARY SERVICE COST CENTERS											
50.00	05000	OPERATING ROOM	20,453,253	47,266,062	67,719,315	0.072612	0.000000			50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000			51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,570,847	84,174	1,655,021	0.397502	0.000000			52.00	
53.00	05300	ANESTHESIOLOGY	7,001,842	12,980,454	19,982,296	0.007524	0.000000			53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,054,969	45,550,898	54,605,867	0.070467	0.000000			54.00	
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000			54.01	
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000			56.00	
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000			57.00	
58.00	05800	MRI	0	0	0	0.000000	0.000000			58.00	
60.00	06000	LABORATORY	16,136,418	52,364,844	68,501,262	0.051894	0.000000			60.00	
65.00	06500	RESPIRATORY THERAPY	4,227,854	2,070,766	6,298,620	0.134941	0.000000			65.00	
66.00	06600	PHYSICAL THERAPY	3,018,286	277,741	3,296,027	0.288070	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	3,214,717	11,168,186	14,382,903	0.093968	0.000000			69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,853,743	2,061,592	4,915,335	0.267009	0.000000			71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,969,221	6,518,730	14,487,951	0.115492	0.000000			72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,281,006	3,733,529	8,014,535	0.294062	0.000000			73.00	
74.00	07400	RENAL DIALYSIS	700,408	89,180	789,588	0.251835	0.000000			74.00	
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000			76.00	
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000			76.01	
76.03	03950	WOUND CARE	8,150	6,170,154	6,178,304	0.192264	0.000000			76.03	
OUTPATIENT SERVICE COST CENTERS											
91.00	09100	EMERGENCY	5,368,049	30,435,264	35,803,313	0.087685	0.000000			91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,224,420	3,039,653	4,264,073	0.227945	0.000000			92.00	
OTHER REIMBURSABLE COST CENTERS											
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000			95.00	
200.00		Subtotal (see instructions)	129,141,181	223,811,227	352,952,408					200.00	
201.00		Less Observation Beds								201.00	
202.00		Total (see instructions)	129,141,181	223,811,227	352,952,408					202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0040	Period: From 05/01/2018 To 04/30/2019	Worksheet C Part I Date/Time Prepared: 9/30/2019 10:39 am
Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital
			11.00		PPS
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
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.072612		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.397502		52.00
53.00	05300	ANESTHESIOLOGY	0.007524		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.070467		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.051894		60.00
65.00	06500	RESPIRATORY THERAPY	0.134941		65.00
66.00	06600	PHYSICAL THERAPY	0.288070		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.093968		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.267009		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.115492		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294062		73.00
74.00	07400	RENAL DIALYSIS	0.251835		74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.03	03950	WOUND CARE	0.192264		76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.087685		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.227945		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part II
Date/Time Prepared:
9/30/2019 10:39 am

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,917,208	476,276	4,440,932	0	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	657,874	29,647	628,227	0	0
53.00	05300	ANESTHESIOLOGY	150,347	20,369	129,978	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,847,899	308,460	3,539,439	0	0
54.01	05401	ULTRASOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	3,554,830	246,743	3,308,087	0	0
65.00	06500	RESPIRATORY THERAPY	849,942	74,921	775,021	0	0
66.00	06600	PHYSICAL THERAPY	949,485	81,602	867,883	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	1,351,528	169,554	1,181,974	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,312,441	51,404	1,261,037	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,673,249	80,867	1,592,382	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,356,769	93,791	2,262,978	0	0
74.00	07400	RENAL DIALYSIS	198,846	2,661	196,185	0	0
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0
76.01	03610	SLEEP LAB	0	0	0	0	0
76.03	03950	WOUND CARE	1,187,868	111,604	1,076,264	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,139,409	192,859	2,946,550	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	971,973	107,262	864,711	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
200.00		Subtotal (sum of lines 50 thru 199)	27,119,668	2,048,020	25,071,648	0	0
201.00		Less Observation Beds	971,973	107,262	864,711	0	0
202.00		Total (line 200 minus line 201)	26,147,695	1,940,758	24,206,937	0	0

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

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part II
Date/Time Prepared:
9/30/2019 10:39 am

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,917,208	67,719,315	0.072612	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	657,874	1,655,021	0.397502	52.00
53.00	05300	ANESTHESIOLOGY	150,347	19,982,296	0.007524	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,847,899	54,605,867	0.070467	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0.000000	58.00
60.00	06000	LABORATORY	3,554,830	68,501,262	0.051894	60.00
65.00	06500	RESPIRATORY THERAPY	849,942	6,298,620	0.134941	65.00
66.00	06600	PHYSICAL THERAPY	949,485	3,296,027	0.288070	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,351,528	14,382,903	0.093968	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,312,441	4,915,335	0.267009	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,673,249	14,487,951	0.115492	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,356,769	8,014,535	0.294062	73.00
74.00	07400	RENAL DIALYSIS	198,846	789,588	0.251835	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	76.01
76.03	03950	WOUND CARE	1,187,868	6,178,304	0.192264	76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,139,409	35,803,313	0.087685	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	971,973	4,264,073	0.227945	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	95.00
200.00		Subtotal (sum of lines 50 thru 199)	27,119,668	310,894,410		200.00
201.00		Less Observation Beds	971,973	0		201.00
202.00		Total (line 200 minus line 201)	26,147,695	310,894,410		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part I
Date/Time Prepared:
9/30/2019 10:39 am

			Title XVIII		Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	788,247	0	788,247	5,857	134.58	30.00	
31.00	INTENSIVE CARE UNIT	167,378		167,378	888	188.49	31.00	
40.00	SUBPROVIDER - IPF	299,252	0	299,252	3,831	78.11	40.00	
43.00	NURSERY	39,089		39,089	751	52.05	43.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
200.00	Total (lines 30 through 199)	1,293,966		1,293,966	11,327		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,339	314,783					30.00
31.00	INTENSIVE CARE UNIT	460	86,705					31.00
40.00	SUBPROVIDER - IPF	2,393	186,917					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30 through 199)	5,192	588,405					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part II
Date/Time Prepared:
9/30/2019 10:39 am

			Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	476,276	67,719,315	0.007033	6,414,060	45,110	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,647	1,655,021	0.017913	4,740	85	52.00
53.00	05300	ANESTHESIOLOGY	20,369	19,982,296	0.001019	2,099,391	2,139	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,460	54,605,867	0.005649	4,063,723	22,956	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	246,743	68,501,262	0.003602	6,355,446	22,892	60.00
65.00	06500	RESPIRATORY THERAPY	74,921	6,298,620	0.011895	2,131,276	25,352	65.00
66.00	06600	PHYSICAL THERAPY	81,602	3,296,027	0.024758	1,126,962	27,901	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	169,554	14,382,903	0.011789	1,642,850	19,368	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,404	4,915,335	0.010458	1,480,400	15,482	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,867	14,487,951	0.005582	2,384,270	13,309	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	93,791	8,014,535	0.011703	1,516,998	17,753	73.00
74.00	07400	RENAL DIALYSIS	2,661	789,588	0.003370	338,940	1,142	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03950	WOUND CARE	111,604	6,178,304	0.018064	7,838	142	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	192,859	35,803,313	0.005387	2,637,496	14,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	107,262	4,264,073	0.025155	455,688	11,463	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,048,020	310,894,410		32,660,078	239,302	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0040		Period: From 05/01/2018 To 04/30/2019		Worksheet D Part III Date/Time Prepared: 9/30/2019 10:39 am		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
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	5,857	0.00	2,339		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	888	0.00	460		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	3,831	0.00	2,393		40.00		
43.00	04300	NURSERY	0	0	751	0.00	0		43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0		44.00		
200.00		Total (lines 30 through 199)	0	0	11,327		5,192		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
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0040		Period: From 05/01/2018 To 04/30/2019		Worksheet D Part IV Date/Time Prepared: 9/30/2019 10:39 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	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						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part IV
Date/Time Prepared:
9/30/2019 10:39 am

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	67,719,315	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,655,021	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	19,982,296	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54,605,867	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	68,501,262	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,298,620	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,296,027	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	14,382,903	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,915,335	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,487,951	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,014,535	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	789,588	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	6,178,304	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	35,803,313	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,264,073	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	310,894,410		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part IV
Date/Time Prepared:
9/30/2019 10:39 am

Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Title XVIII		Hospital	PPS	
				Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	6,414,060	0	17,230,472	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	4,740	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,099,391	0	4,339,351	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	4,063,723	0	13,059,755	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	6,355,446	0	4,183,259	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,131,276	0	513,632	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,126,962	0	85,269	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	1,642,850	0	4,623,636	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,480,400	0	523,128	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,384,270	0	4,077,508	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,516,998	0	1,442,173	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	338,940	0	21,560	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	7,838	0	2,094,564	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	2,637,496	0	5,571,271	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	455,688	0	1,104,685	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		32,660,078	0	58,870,263	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part V
Date/Time Prepared:
9/30/2019 10:39 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.072612	17,230,472	0	0	1,251,139	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.397502	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007524	4,339,351	0	0	32,649	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.070467	13,059,755	0	0	920,282	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.051894	4,183,259	0	0	217,086	60.00
65.00	06500	RESPIRATORY THERAPY	0.134941	513,632	0	0	69,310	65.00
66.00	06600	PHYSICAL THERAPY	0.288070	85,269	0	0	24,563	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	0.093968	4,623,636	0	0	434,474	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.267009	523,128	0	0	139,680	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.115492	4,077,508	0	0	470,920	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294062	1,442,173	9,571	0	424,088	73.00
74.00	07400	RENAL DIALYSIS	0.251835	21,560	0	0	5,430	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.192264	2,094,564	0	0	402,709	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.087685	5,571,271	0	0	488,517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.227945	1,104,685	0	0	251,807	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		58,870,263	9,571	0	5,132,654	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		58,870,263	9,571	0	5,132,654	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0040		Period: From 05/01/2018 To 04/30/2019		Worksheet D Part V Date/Time Prepared: 9/30/2019 10:39 am		
			Title XVIII		Hospital		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
54.01	05401	ULTRASOUND	0	0					54.01
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,814	0					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0					76.00
76.01	03610	SLEEP LAB	0	0					76.01
76.03	03950	WOUND CARE	0	0					76.03
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0						95.00
200.00		Subtotal (see instructions)	2,814	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	2,814	0					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0040	Period: From 05/01/2018 To 04/30/2019	Worksheet D Part II Date/Time Prepared: 9/30/2019 10:39 am		
				Component CCN: 14-S040				
				Title XVIII		Subprovider - IPF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	476,276	67,719,315	0.007033	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,647	1,655,021	0.017913	0	0	52.00
53.00	05300	ANESTHESIOLOGY	20,369	19,982,296	0.001019	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,460	54,605,867	0.005649	368,642	2,082	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	246,743	68,501,262	0.003602	1,340,440	4,828	60.00
65.00	06500	RESPIRATORY THERAPY	74,921	6,298,620	0.011895	420,382	5,000	65.00
66.00	06600	PHYSICAL THERAPY	81,602	3,296,027	0.024758	545,267	13,500	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	169,554	14,382,903	0.011789	108,678	1,281	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,404	4,915,335	0.010458	604	6	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,867	14,487,951	0.005582	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	93,791	8,014,535	0.011703	654,203	7,656	73.00
74.00	07400	RENAL DIALYSIS	2,661	789,588	0.003370	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03950	WOUND CARE	111,604	6,178,304	0.018064	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	192,859	35,803,313	0.005387	215,819	1,163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,264,073	0.000000	18,728	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,940,758	310,894,410		3,672,763	35,516	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0040 Component CCN: 14-S040		Period: From 05/01/2018 To 04/30/2019		Worksheet D Part IV Date/Time Prepared: 9/30/2019 10:39 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	ULTRASOUND		0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS		0	0	0	0	0	76.00
76.01	03610	SLEEP LAB		0	0	0	0	0	76.01
76.03	03950	WOUND CARE		0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0040 Component CCN: 14-S040		Period: From 05/01/2018 To 04/30/2019		Worksheet D Part IV Date/Time Prepared: 9/30/2019 10:39 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	67,719,315	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,655,021	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	19,982,296	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54,605,867	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	68,501,262	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,298,620	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,296,027	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	14,382,903	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,915,335	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,487,951	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,014,535	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	789,588	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	6,178,304	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	35,803,313	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,264,073	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	310,894,410		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0040 Component CCN: 14-S040		Period: From 05/01/2018 To 04/30/2019		Worksheet D Part IV Date/Time Prepared: 9/30/2019 10:39 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	368,642	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,340,440	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	420,382	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	545,267	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	108,678	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	604	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	654,203	0	0	746	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0.000000	215,819	0	0	1,050	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	18,728	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			3,672,763	0	1,796	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0040

Period:

Worksheet D

Component CCN: 14-S040

From 05/01/2018

Part V

To 04/30/2019

Date/Time Prepared:
9/30/2019 10:39 am

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						
50.00	05000 OPERATING ROOM	0.072612	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.397502	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.007524	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.070467	0	0	0	0 54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0 54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0 56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0 57.00
58.00	05800 MRI	0.000000	0	0	0	0 58.00
60.00	06000 LABORATORY	0.051894	0	0	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	0.134941	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.288070	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	0.093968	0	0	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.267009	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.115492	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.294062	746	0	0	219 73.00
74.00	07400 RENAL DIALYSIS	0.251835	0	0	0	0 74.00
76.00	03560 OTHER ANCILLARY COSTS	0.000000	0	0	0	0 76.00
76.01	03610 SLEEP LAB	0.000000	0	0	0	0 76.01
76.03	03950 WOUND CARE	0.192264	0	0	0	0 76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0.087685	1,050	0	0	92 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.227945	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.000000		0		95.00
200.00	Subtotal (see instructions)		1,796	0	0	311 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		1,796	0	0	311 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0040	Period: From 05/01/2018 To 04/30/2019	Worksheet D Part V Date/Time Prepared: 9/30/2019 10:39 am	
			Component CCN: 14-S040			
			Title XVIII	Subprovider - IPF	PPS	
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
54.01	05401	ULTRASOUND	0	0	54.01	
56.00	05600	RADIOISOTOPE	0	0	56.00	
57.00	05700	CT SCAN	0	0	57.00	
58.00	05800	MRI	0	0	58.00	
60.00	06000	LABORATORY	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	74.00	
76.00	03560	OTHER ANCILLARY COSTS	0	0	76.00	
76.01	03610	SLEEP LAB	0	0	76.01	
76.03	03950	WOUND CARE	0	0	76.03	
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0		95.00	
200.00		Subtotal (see instructions)	0	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 ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part I
Date/Time Prepared:
9/30/2019 10:39 am

			Title XIX		Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	788,247	0	788,247	5,857	134.58	30.00	
31.00	INTENSIVE CARE UNIT	167,378		167,378	888	188.49	31.00	
40.00	SUBPROVIDER - IPF	299,252	0	299,252	3,831	78.11	40.00	
43.00	NURSERY	39,089		39,089	751	52.05	43.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
200.00	Total (lines 30 through 199)	1,293,966		1,293,966	11,327		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	103	13,862					30.00
31.00	INTENSIVE CARE UNIT	19	3,581					31.00
40.00	SUBPROVIDER - IPF	5	391					40.00
43.00	NURSERY	120	6,246					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30 through 199)	247	24,080					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part II
Date/Time Prepared:
9/30/2019 10:39 am

Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	476,276	67,719,315	0.007033	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	29,647	1,655,021	0.017913	0	0	52.00
53.00	05300 ANESTHESIOLOGY	20,369	19,982,296	0.001019	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	308,460	54,605,867	0.005649	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MRI	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	246,743	68,501,262	0.003602	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	74,921	6,298,620	0.011895	0	0	65.00
66.00	06600 PHYSICAL THERAPY	81,602	3,296,027	0.024758	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	169,554	14,382,903	0.011789	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	51,404	4,915,335	0.010458	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	80,867	14,487,951	0.005582	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	93,791	8,014,535	0.011703	0	0	73.00
74.00	07400 RENAL DIALYSIS	2,661	789,588	0.003370	0	0	74.00
76.00	03560 OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03610 SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03950 WOUND CARE	111,604	6,178,304	0.018064	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	192,859	35,803,313	0.005387	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	107,262	4,264,073	0.025155	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	2,048,020	310,894,410		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0040		Period: From 05/01/2018 To 04/30/2019		Worksheet D Part III Date/Time Prepared: 9/30/2019 10:39 am		
					Title XIX		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	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		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
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	5,857	0.00	103		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	888	0.00	19		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	3,831	0.00	5		40.00		
43.00	04300	NURSERY	0	0	751	0.00	120		43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0		44.00		
200.00		Total (lines 30 through 199)	0	0	11,327		247		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
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet D
Part IV
Date/Time Prepared:
9/30/2019 10:39 am

Cost Center Description		Title XIX			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part IV
Date/Time Prepared:
9/30/2019 10:39 am

Cost Center Description			Title XIX		Hospital	PPS		
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)		Ratio of Cost to Charges (col. 5 ÷ col. 7)
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	67,719,315	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,655,021	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	19,982,296	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54,605,867	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	68,501,262	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,298,620	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,296,027	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	14,382,903	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,915,335	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,487,951	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,014,535	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	789,588	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	6,178,304	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	35,803,313	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,264,073	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	310,894,410		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part IV
Date/Time Prepared:
9/30/2019 10:39 am

				Title XIX		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
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
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0040	Period: From 05/01/2018 To 04/30/2019	Worksheet D-1 Date/Time Prepared: 9/30/2019 10:39 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,857	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,857	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,060	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,339	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)		7,142,828	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)		7,142,828	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)		7,142,828	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,219.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,852,504	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,852,504	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet D-1

Date/Time Prepared:
9/30/2019 10:39 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	2,581,792	888	2,907.42	460	1,337,413
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
	Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,404,942
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,594,859
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					401,488
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					239,302
52.00	Total Program excludable cost (sum of lines 50 and 51)					640,790
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,954,069
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	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)					797
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,219.54
89.00	Observation bed cost (line 87 x line 88) (see instructions)					971,973

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet D-1

Date/Time Prepared:
9/30/2019 10:39 am

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	788,247	7,142,828	0.110355	971,973	107,262	90.00
91.00	Nursing School cost	0	7,142,828	0.000000	971,973	0	91.00
92.00	Allied health cost	0	7,142,828	0.000000	971,973	0	92.00
93.00	All other Medical Education	0	7,142,828	0.000000	971,973	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0040 Component CCN: 14-S040	Period: From 05/01/2018 To 04/30/2019	Worksheet D-1 Date/Time Prepared: 9/30/2019 10:39 am
		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)		3,831	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,831	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)		3,831	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,393	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,290,468	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,290,468	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,290,468	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)		858.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,055,372	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,055,372	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0040	Period: From 05/01/2018 To 04/30/2019	Worksheet D-1	
				Component CCN: 14-S040		Date/Time Prepared: 9/30/2019 10:39 am	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	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)					535,282	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,590,654	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)					186,917	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					35,516	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					222,433	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,368,221	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: 14-0040 Component CCN: 14-S040		Period: From 05/01/2018 To 04/30/2019		Worksheet D-1 Date/Time Prepared: 9/30/2019 10:39 am	
		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	299,252	3,290,468	0.090945	0	0	90.00
91.00	Nursing School cost	0	3,290,468	0.000000	0	0	91.00
92.00	Allied health cost	0	3,290,468	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,290,468	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0040	Period: From 05/01/2018 To 04/30/2019	Worksheet D-1 Date/Time Prepared: 9/30/2019 10:39 am
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,857 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,857 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			5,060 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)			103 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)			751 15.00
16.00	Nursery days (title V or XIX only)			120 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)			7,142,828 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)			7,142,828 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)			7,142,828 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,219.54 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			125,613 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)			125,613 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet D-1

Date/Time Prepared:
9/30/2019 10:39 am

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)	PPS
Cost Center Description			1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)		756,881	751	1,007.83	120	120,940	42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT		2,581,792	888	2,907.42	19	55,241	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)						301,794	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)						23,689	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)						23,689	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						278,105	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)						797	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,219.54	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						971,973	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet D-1

Date/Time Prepared:
9/30/2019 10:39 am

Cost Center Description		Title XIX		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	788,247	7,142,828	0.110355	971,973	107,262
91.00	Nursing School cost	0	7,142,828	0.000000	971,973	0
92.00	Allied health cost	0	7,142,828	0.000000	971,973	0
93.00	All other Medical Education	0	7,142,828	0.000000	971,973	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0040	Period: From 05/01/2018 To 04/30/2019	Worksheet D-3 Date/Time Prepared: 9/30/2019 10:39 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		8,453,269	30.00
31.00	03100	INTENSIVE CARE UNIT		3,403,910	31.00
40.00	04000	SUBPROVIDER - IPF		97,172	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.072612	6,414,060	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.397502	4,740	52.00
53.00	05300	ANESTHESIOLOGY	0.007524	2,099,391	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.070467	4,063,723	54.00
54.01	05401	ULTRASOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
60.00	06000	LABORATORY	0.051894	6,355,446	60.00
65.00	06500	RESPIRATORY THERAPY	0.134941	2,131,276	65.00
66.00	06600	PHYSICAL THERAPY	0.288070	1,126,962	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	0.093968	1,642,850	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.267009	1,480,400	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.115492	2,384,270	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294062	1,516,998	73.00
74.00	07400	RENAL DIALYSIS	0.251835	338,940	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	76.01
76.03	03950	WOUND CARE	0.192264	7,838	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.087685	2,637,496	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.227945	455,688	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		32,660,078	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		32,660,078	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0040 Component CCN: 14-S040	Period: From 05/01/2018 To 04/30/2019	Worksheet D-3 Date/Time Prepared: 9/30/2019 10:39 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		7,694,914		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.072612	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.397502	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.007524	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.070467	368,642	25,977	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.051894	1,340,440	69,561	60.00
65.00	06500 RESPIRATORY THERAPY	0.134941	420,382	56,727	65.00
66.00	06600 PHYSICAL THERAPY	0.288070	545,267	157,075	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	0.093968	108,678	10,212	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.267009	604	161	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.115492	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.294062	654,203	192,376	73.00
74.00	07400 RENAL DIALYSIS	0.251835	0	0	74.00
76.00	03560 OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03610 SLEEP LAB	0.000000	0	0	76.01
76.03	03950 WOUND CARE	0.192264	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.087685	215,819	18,924	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.227945	18,728	4,269	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,672,763	535,282	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		3,672,763		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0040	Period: From 05/01/2018 To 04/30/2019	Worksheet E Part A Date/Time Prepared: 9/30/2019 10:39 am
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		1,849,753	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,773,620	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)		39,418	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)		93.82	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)		5.41	30.00
31.00	Percentage of Medicaid patient days (see instructions)		28.63	31.00
32.00	Sum of lines 30 and 31		34.04	32.00
33.00	Allowable disproportionate share percentage (see instructions)		17.30	33.00
34.00	Disproportionate share adjustment (see instructions)		199,961	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0040	Period: From 05/01/2018 To 04/30/2019	Worksheet E Part A Date/Time Prepared: 9/30/2019 10:39 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	351,860	343,425		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	147,492	199,469		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	346,961			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)	5,209,713			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	5,494,769			48.00
			Amount		
			1.00		
49.00	Total payment for inpatient operating costs (see instructions)			5,423,505	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			380,977	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)			5,804,482	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			5,804,482	61.00
62.00	Deductibles billed to program beneficiaries			582,456	62.00
63.00	Coinsurance billed to program beneficiaries			3,685	63.00
64.00	Allowable bad debts (see instructions)			185,063	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			120,291	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			167,525	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			5,338,632	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)			-553	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			-1,782	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-11,732	70.93
70.94	HRR adjustment amount (see instructions)			-37,822	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet E
Part A
Date/Time Prepared:
9/30/2019 10:39 am

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	0	70.97
70.98	Low Volume Payment-3		0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,286,743	71.00	
71.01	Sequestration adjustment (see instructions)		105,735	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		5,205,682	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)		-24,674	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		737,939	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)	89,617	124,175	100.00	
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.9959962314	0.9984404452	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	-359	-194	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.9869	0.9951	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-1,174	-608	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: 14-0040	Period: From 05/01/2018 To 04/30/2019	Worksheet E Part B Date/Time Prepared: 9/30/2019 10:39 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,814	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,132,654	2.00
3.00	OPPS payments		4,647,118	3.00
4.00	Outlier payment (see instructions)		34,451	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)		2,814	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		9,571	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)		9,571	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)		9,571	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		6,757	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)		2,814	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)		4,681,569	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)		895,794	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		3,788,589	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)		3,788,589	30.00
31.00	Primary payer payments		134	31.00
32.00	Subtotal (line 30 minus line 31)		3,788,455	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)		154,729	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		100,574	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		149,115	36.00
37.00	Subtotal (see instructions)		3,889,029	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,889,029	40.00
40.01	Sequestration adjustment (see instructions)		77,781	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,822,563	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-11,315	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: 14-0040	Period: From 05/01/2018 To 04/30/2019	Worksheet E Part B Date/Time Prepared: 9/30/2019 10:39 am
		Component CCN: 14-S040		
		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 OPSS (see instructions)		311	2.00
3.00	OPPS payments		440	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)		440	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)		440	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)		440	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		440	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)		440	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)		440	40.00
40.01	Sequestration adjustment (see instructions)		9	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		431	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: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet E-1
Part I
Date/Time Prepared:
9/30/2019 10:39 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,205,682		3,822,563	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)		5,205,682		3,822,563	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		24,674		11,315	6.02
7.00	Total Medicare program liability (see instructions)		5,181,008		3,811,248	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: 14-0040 Component CCN: 14-S040	Period: From 05/01/2018 To 04/30/2019	Worksheet E-1 Part I Date/Time Prepared: 9/30/2019 10:39 am	
		Title XVIII	Subprovider - IPF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				
2.00	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		2,201,889		431
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,201,889		431
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		26,639		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		2,228,528		431
				Contractor Number	NPR Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor				

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0040	Period: From 05/01/2018 To 04/30/2019	Worksheet E-1 Part II Date/Time Prepared: 9/30/2019 10:39 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0040 Component CCN: 14-S040	Period: From 05/01/2018 To 04/30/2019	Worksheet E-3 Part II Date/Time Prepared: 9/30/2019 10:39 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,387,408 1.00
2.00	Net IPF PPS Outlier Payments			23,431 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)			10.495890 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)			2,410,839 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)			2,410,839 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,410,839 18.00
19.00	Deductibles			99,664 19.00
20.00	Subtotal (line 18 minus line 19)			2,311,175 20.00
21.00	Coinsurance			64,350 21.00
22.00	Subtotal (line 20 minus line 21)			2,246,825 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			41,820 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			27,183 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			39,901 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,274,008 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			2,274,008 31.00
31.01	Sequestration adjustment (see instructions)			45,480 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			2,201,889 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)			26,639 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			23,431 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet G

Date/Time Prepared:
9/30/2019 10:39 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-162,152	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	9,153,116	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,235,923	0	0	0	6.00
7.00	Inventory	1,400,477	0	0	0	7.00
8.00	Prepaid expenses	738,019	0	0	0	8.00
9.00	Other current assets	304,362	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)	9,197,899	0	0	0	11.00
FIXED ASSETS						
12.00	Land	259,268	0	0	0	12.00
13.00	Land improvements	554,380	0	0	0	13.00
14.00	Accumulated depreciation	-515,210	0	0	0	14.00
15.00	Buildings	15,729,839	0	0	0	15.00
16.00	Accumulated depreciation	-7,781,622	0	0	0	16.00
17.00	Leasehold improvements	15,405,071	0	0	0	17.00
18.00	Accumulated depreciation	-7,438,123	0	0	0	18.00
19.00	Fixed equipment	4,262,728	0	0	0	19.00
20.00	Accumulated depreciation	-2,454,278	0	0	0	20.00
21.00	Automobiles and trucks	30,160	0	0	0	21.00
22.00	Accumulated depreciation	-30,160	0	0	0	22.00
23.00	Major movable equipment	11,916,774	0	0	0	23.00
24.00	Accumulated depreciation	-10,265,458	0	0	0	24.00
25.00	Minor equipment depreciable	5,021,236	0	0	0	25.00
26.00	Accumulated depreciation	-4,713,825	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)	19,980,780	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,627,644	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,627,644	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	31,806,323	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,800,740	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,244,905	0	0	0	38.00
39.00	Payroll taxes payable	175,895	0	0	0	39.00
40.00	Notes and loans payable (short term)	438,069	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	-14,874,505	0	0	0	43.00
44.00	Other current liabilities	782,925	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-10,431,971	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	640,824	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	640,824	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-9,791,147	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	41,597,470				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)	41,597,470	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	31,806,323	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet G-1

Date/Time Prepared:
9/30/2019 10:39 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		44,000,330		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,402,879				2.00
3.00	Total (sum of line 1 and line 2)		41,597,451		0		3.00
4.00	ROUNDING	19		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)		19		0		10.00
11.00	Subtotal (line 3 plus line 10)		41,597,470		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)		41,597,470		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	ROUNDING		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
9/30/2019 10:39 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	20,828,839		20,828,839	1.00
2.00	SUBPROVIDER - IPF	14,654,915		14,654,915	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	35,483,754		35,483,754	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,574,244		6,574,244	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)	6,574,244		6,574,244	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	42,057,998		42,057,998	17.00
18.00	Ancillary services	80,490,714	190,336,310	270,827,024	18.00
19.00	Outpatient services	6,592,469	33,474,917	40,067,386	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	129,141,181	223,811,227	352,952,408	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		53,474,476		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)		53,474,476		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2018
To 04/30/2019

Worksheet G-3

Date/Time Prepared:
9/30/2019 10:39 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	352,952,408	1.00
2.00	Less contractual allowances and discounts on patients' accounts	301,919,030	2.00
3.00	Net patient revenues (line 1 minus line 2)	51,033,378	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	53,474,476	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,441,098	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	38,219	24.00
25.00	Total other income (sum of lines 6-24)	38,219	25.00
26.00	Total (line 5 plus line 25)	-2,402,879	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)	-2,402,879	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0040	Period: From 05/01/2018 To 04/30/2019	Worksheet L Parts I-III Date/Time Prepared: 9/30/2019 10:39 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		373,767	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		7,210	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		16.65	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		380,977	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00