

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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0058	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/28/2020 9:15 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/28/2020	Time: 9:15 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 PASSAVANT AREA HOSPITAL (14-0058) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 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) PAUL EDDINGTON

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

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	-1,021	48,989	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	-17		0	7.00
200.00	Total	0	-1,021	48,972	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: 14-0058		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/28/2020 9:15 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1600 WEST WALNUT			PO Box:				1.00	
2.00	City: JACKSONVILLE			State: IL		Zip Code: 62650-1185		County: MORGAN	
		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			PASSAVANT AREA HOSPITAL	140058	99914	1	07/01/1966	N
4.00	Subprovider - IPF			PASSAVANT AREA HOSPITAL	14S058	99914	4	10/01/2016	N
5.00	Subprovider - IRF								P
6.00	Subprovider - (Other)								N
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF			PASSAVANT AREA HOSPITAL	145951	99914		10/31/1997	N
10.00	Hospital-Based NF								P
11.00	Hospital-Based OLTC								N
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)						10/01/2018	09/30/2019	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	
							2.00	3.00	
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			423	221	1	0	1,029	81

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
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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.					1		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.					10/01/2018	09/30/2019	36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	45.00
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	48.00
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		57.00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)				N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/28/2020 9:15 am

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

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To 09/30/2019Worksheet S-2
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	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	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y				70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0		71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0		76.00

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0058	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/28/2020 9:15 am	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	402,457	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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		14H058	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0058		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/28/2020 9:15 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: MEMORIAL HEALTH SYSTEMS		Contractor's Name: MEMORIAL HEALTH SYSTEMS		Contractor's Number: 00131				141.00
142.00	Street: 701 NORTH FIRST STREET		PO Box:						142.00
143.00	City: SPRINGFIELD		State: IL		Zip Code: 62781				143.00
								1.00	
144.00 Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					Y		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N		146.00	
								1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N	155.00	
156.00	Subprovider - IPF			N	N	N	N	156.00	
157.00	Subprovider - IRF			N	N	N	N	157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF			N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N	160.00	
161.00	CMHC				N	N	N	161.00	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N		165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y		167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00		169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N		0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0058	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/28/2020 9:15 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/17/2019
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		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 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N	02/13/2020	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/28/2020 9:15 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.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/28/2020 9:15 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/28/2020 9:15 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	93	33,945	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)		93	33,945	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	9	3,285	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)		102	37,230	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	4	1,460		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	15	5,475		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)		121			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: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/28/2020 9:15 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,070	269	7,822			1.00
2.00	HMO and other (see instructions)	691	1,251				2.00
3.00	HMO IPF Subprovider	0	216				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,070	269	7,822			7.00
8.00	INTENSIVE CARE UNIT	570	99	973			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		55	744			13.00
14.00	Total (see instructions)	4,640	423	9,539	0.00	692.84	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	57	773	0.00	10.51	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,128	0	4,434	0.00	21.47	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	724.82	27.00
28.00	Observation Bed Days		275	1,217			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			164			31.00
32.00	Labor & delivery days (see instructions)	0	81	159			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: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/28/2020 9:15 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	1,315	468	2,782	1.00
2.00 HMO and other (see instructions)			182	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	1,315	468	2,782	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	67	136	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: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/28/2020 9:15 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	43,808,976	0	43,808,976	1,401,422.59	31.26	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		250,502	-64,359	186,143	2,080.00	89.49	3.00
4.00	Physician-Part A - Administrative		1,100	0	1,100	5.50	200.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		445,204	0	445,204	2,720.15	163.67	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,073,696	0	1,073,696	43,805.17	24.51	9.00
10.00	Excluded area salaries (see instructions)		1,266,163	0	1,266,163	37,471.75	33.79	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		477,118	0	477,118	7,027.07	67.90	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		183,702	0	183,702	1,359.47	135.13	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		49,452	0	49,452	2,080.00	23.78	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		14,402,965	0	14,402,965			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		768,177	0	768,177			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		40,855	0	40,855			21.00
22.00	Physician Part A - Administrative		260	0	260			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		249,525	0	249,525			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		9,257	0	9,257			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	364,698	0	364,698	8,002.85	45.57	26.00
27.00	Administrative & General	5.00	7,191,069	0	7,191,069	187,422.85	38.37	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/28/2020 9:15 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.)		47,750	0	47,750	241.79	197.49	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,521,097	0	1,521,097	62,540.89	24.32	30.00
31.00	Laundry & Linen Service	8.00	253,560	0	253,560	16,777.65	15.11	31.00
32.00	Housekeeping	9.00	1,118,116	0	1,118,116	79,697.02	14.03	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,119,635	-742,574	377,061	23,637.04	15.95	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	742,574	742,574	46,550.06	15.95	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,045,547	0	1,045,547	26,412.48	39.59	38.00
39.00	Central Services and Supply	14.00	181,666	0	181,666	10,626.49	17.10	39.00
40.00	Pharmacy	15.00	1,040,833	-1,040,833	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	913,810	0	913,810	39,515.16	23.13	41.00
42.00	Social Service	17.00	410,141	0	410,141	10,689.83	38.37	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part III
Date/Time Prepared:
2/28/2020 9:15 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)	43,161,020	64,359	43,225,379	1,396,864.23	30.94	1.00
2.00	Excluded area salaries (see instructions)	2,339,859	0	2,339,859	81,276.92	28.79	2.00
3.00	Subtotal salaries (line 1 minus line 2)	40,821,161	64,359	40,885,520	1,315,587.31	31.08	3.00
4.00	Subtotal other wages & related costs (see inst.)	710,272	0	710,272	10,466.54	67.86	4.00
5.00	Subtotal wage-related costs (see inst.)	14,412,482	0	14,412,482	0.00	35.25	5.00
6.00	Total (sum of lines 3 thru 5)	55,943,915	64,359	56,008,274	1,326,053.85	42.24	6.00
7.00	Total overhead cost (see instructions)	15,207,922	-1,040,833	14,167,089	512,114.11	27.66	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part IV
Date/Time Prepared:
2/28/2020 9:15 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	2,866,090	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)	8,489,565	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	24,182	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	93,634	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	521,433	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	3,251,147	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	57,693	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	158,038	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	15,461,782	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part V
Date/Time Prepared:
2/28/2020 9:15 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	477,118	15,461,782	1.00
2.00	Hospital	477,118	15,461,782	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: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet S-7

Date/Time Prepared:
2/28/2020 9:15 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.	N			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N			2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	30	0	30 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	15	0	15 8.00
9.00		RMX	13	0	13 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	8	0	8 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	302	0	302 15.00
16.00		RVB	135	0	135 16.00
17.00		RVA	299	0	299 17.00
18.00		RHC	483	0	483 18.00
19.00		RHB	445	0	445 19.00
20.00		RHA	1,054	0	1,054 20.00
21.00		RMC	76	0	76 21.00
22.00		RMB	54	0	54 22.00
23.00		RMA	36	0	36 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	8	0	8 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	2	0	2 32.00
33.00		HC2	8	0	8 33.00
34.00		HC1	54	0	54 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	19	0	19 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	41	0	41 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	3	0	3 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	2	0	2 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	40	0	40 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: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet S-7

Date/Time Prepared:
2/28/2020 9:15 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	1	0	1	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		3,128	0	3,128	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).			99914	99914	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		1,073,696	17.67	Y	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)		6,074,805			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0058	Period: From 10/01/2018 To 09/30/2019	Worksheet S-10 Date/Time Prepared: 2/28/2020 9:15 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)			0.220144 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	7,497,106		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	4,487,734		5.00
6.00	Medicaid charges	86,755,260		6.00
7.00	Medicaid cost (line 1 times line 6)	19,098,650		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)	7,113,810		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	45,845		9.00
10.00	Stand-alone CHIP charges	467,248		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	102,862		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	57,017		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)	7,170,827		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)	7,900,341	36,659	7,937,000 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,739,213	36,659	1,775,872 21.00
22.00	Payments received from patients for amounts previously written off as charity care	165,862	4,842	170,704 22.00
23.00	Cost of charity care (line 21 minus line 22)	1,573,351	31,817	1,605,168 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,201,026		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	716,099		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,101,690		27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,099,336		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	847,747		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,452,915		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,623,742		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/28/2020 9:15 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		1,705,205	1,705,205	566,182	2,271,387	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,625,464	2,625,464	18,542	2,644,006	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	364,698	15,430,398	15,795,096	0	15,795,096	4.00
5.01	00540	NONPATIENT TELEPHONES	0	116,677	116,677	0	116,677	5.01
5.02	00550	DATA PROCESSING	955,499	1,645,880	2,601,379	0	2,601,379	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	288,326	161,977	450,303	0	450,303	5.03
5.04	00570	ADMITTING	742,519	30,288	772,807	0	772,807	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	687,290	755,826	1,443,116	0	1,443,116	5.05
5.06	00590	OTHER ADMIN & GENERAL	4,517,435	9,675,786	14,193,221	-49,744	14,143,477	5.06
7.00	00700	OPERATION OF PLANT	1,521,097	2,761,254	4,282,351	0	4,282,351	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	253,560	104,360	357,920	0	357,920	8.00
9.00	00900	HOUSEKEEPING	1,118,116	193,576	1,311,692	0	1,311,692	9.00
10.00	01000	DIETARY	1,119,635	1,291,609	2,411,244	-1,599,206	812,038	10.00
11.00	01100	CAFETERIA	0	0	0	1,599,206	1,599,206	11.00
13.00	01300	NURSING ADMINISTRATION	1,045,547	61,575	1,107,122	0	1,107,122	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	181,666	107,318	288,984	-1,826	287,158	14.00
15.00	01500	PHARMACY	1,040,833	164,036	1,204,869	-876,636	328,233	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	913,810	61,851	975,661	0	975,661	16.00
17.00	01700	SOCIAL SERVICE	410,141	11,466	421,607	0	421,607	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	250,502	300	250,802	-64,359	186,443	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,185,742	2,641,401	6,827,143	-10,082	6,817,061	30.00
31.00	03100	INTENSIVE CARE UNIT	1,035,182	133,038	1,168,220	-3,160	1,165,060	31.00
40.00	04000	SUBPROVIDER - IPF	754,588	117,762	872,350	0	872,350	40.00
43.00	04300	NURSERY	391,705	51,500	443,205	0	443,205	43.00
44.00	04400	SKILLED NURSING FACILITY	1,073,696	109,745	1,183,441	-240	1,183,201	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,508,040	2,891,394	6,399,434	-1,617,633	4,781,801	50.00
51.00	05100	RECOVERY ROOM	367,193	37,277	404,470	-38	404,432	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	97,926	12,875	110,801	0	110,801	52.00
53.00	05300	ANESTHESIOLOGY	0	320,609	320,609	-143,370	177,239	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,633,554	459,049	2,092,603	-2,974	2,089,629	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	544,740	-7,283	537,457	-107	537,350	55.00
56.00	05600	RADIOISOTOPE	195,032	355,317	550,349	-66	550,283	56.00
57.00	05700	CT SCAN	540,976	386,254	927,230	0	927,230	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	325,252	110,771	436,023	0	436,023	58.00
60.00	06000	LABORATORY	1,992,492	2,479,715	4,472,207	-41	4,472,166	60.00
65.00	06500	RESPIRATORY THERAPY	1,171,334	224,180	1,395,514	-499,465	896,049	65.00
66.00	06600	PHYSICAL THERAPY	3,474,334	323,599	3,797,933	-18,025	3,779,908	66.00
67.00	06700	OCCUPATIONAL THERAPY	962,441	40,116	1,002,557	-12,643	989,914	67.00
68.00	06800	SPEECH PATHOLOGY	286,194	5,103	291,297	0	291,297	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,885	3,020	8,905	0	8,905	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,523,616	2,523,616	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,838,423	1,838,423	0	1,838,423	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,949,551	3,949,551	1,040,833	4,990,384	73.00
74.00	07400	RENAL DIALYSIS	114,809	88,540	203,349	-22,732	180,617	74.00
76.00	03950	DIABETIC EDUCATION	233,862	4,726	238,588	0	238,588	76.00
76.97	07697	CARDIAC REHABILITATION	141,774	15,436	157,210	0	157,210	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76,777	28,958	105,735	-4	105,731	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,418,379	1,120,480	2,538,859	-124,682	2,414,177	90.00
91.00	09100	EMERGENCY	3,354,820	2,687,036	6,041,856	-166,301	5,875,555	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		534,980	534,980	-534,980	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,297,401	57,868,418	101,165,819	65	101,165,884	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	287,581	193,758	481,339	-65	481,274	192.00
194.00	07950	RENTED SPACE	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	223,994	86,715	310,709	0	310,709	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	43,808,976	58,148,891	101,957,867	0	101,957,867	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/28/2020 9:15 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	639,015	2,910,402	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,599,266	4,243,272	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,163,047	12,632,049	4.00
5.01	00540	NONPATIENT TELEPHONES	-7,623	109,054	5.01
5.02	00550	DATA PROCESSING	0	2,601,379	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	450,303	5.03
5.04	00570	ADMITTING	0	772,807	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,443,116	5.05
5.06	00590	OTHER ADMIN & GENERAL	-5,855,743	8,287,734	5.06
7.00	00700	OPERATION OF PLANT	248,489	4,530,840	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	357,920	8.00
9.00	00900	HOUSEKEEPING	0	1,311,692	9.00
10.00	01000	DIETARY	-70,871	741,167	10.00
11.00	01100	CAFETERIA	-563,968	1,035,238	11.00
13.00	01300	NURSING ADMINISTRATION	-15,597	1,091,525	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	287,158	14.00
15.00	01500	PHARMACY	0	328,233	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-28,149	947,512	16.00
17.00	01700	SOCIAL SERVICE	0	421,607	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-186,443	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,009,877	4,807,184	30.00
31.00	03100	INTENSIVE CARE UNIT	-26,517	1,138,543	31.00
40.00	04000	SUBPROVIDER - IPF	-92,231	780,119	40.00
43.00	04300	NURSERY	0	443,205	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,183,201	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,218	4,780,583	50.00
51.00	05100	RECOVERY ROOM	0	404,432	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	110,801	52.00
53.00	05300	ANESTHESIOLOGY	0	177,239	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,652	2,087,977	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	537,350	55.00
56.00	05600	RADIOISOTOPE	0	550,283	56.00
57.00	05700	CT SCAN	0	927,230	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	436,023	58.00
60.00	06000	LABORATORY	-75,000	4,397,166	60.00
65.00	06500	RESPIRATORY THERAPY	-1,560	894,489	65.00
66.00	06600	PHYSICAL THERAPY	-77,645	3,702,263	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	989,914	67.00
68.00	06800	SPEECH PATHOLOGY	0	291,297	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,905	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,523,616	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,838,423	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39	4,990,423	73.00
74.00	07400	RENAL DIALYSIS	-66,887	113,730	74.00
76.00	03950	DIABETIC EDUCATION	0	238,588	76.00
76.97	07697	CARDIAC REHABILITATION	0	157,210	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	105,731	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-1,206,188	1,207,989	90.00
91.00	09100	EMERGENCY	-1,774,261	4,101,294	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-12,737,668	88,428,216	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	481,274	192.00
194.00	07950	RENTED SPACE	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	310,709	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-12,737,668	89,220,199	200.00

RECLASSIFICATIONS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/28/2020 9:15 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	534,980	1.00	
	0		0	534,980		
	B - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	49,744	1.00	
	TOTALS		0	49,744		
	C - SPOILED DRUGS					
1.00	PHARMACY	15.00	0	164,197	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
	0		0	164,197		
	D - CHARGEABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,523,616	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
	TOTALS		0	2,523,616		
	E - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	742,574	856,632	1.00	
	0		742,574	856,632		
	F - PHARMACY SALARIES					
1.00	DRUGS CHARGED TO PATIENTS	73.00	1,040,833	0	1.00	
	TOTALS		1,040,833	0		
	G - RN AND AIDE WAGES					
1.00	ANESTHESIOLOGY	53.00	64,359	0	1.00	
	TOTALS		64,359	0		
500.00	Grand Total: Increases		1,847,766	4,129,169	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/28/2020 9:15 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	534,980	11		1.00
	0		0	534,980			
	B - PROPERTY INSURANCE						
1.00	OTHER ADMIN & GENERAL	5.06	0	49,744	12		1.00
	TOTALS		0	49,744			
	C - SPOILED DRUGS						
1.00	ADULTS & PEDIATRICS	30.00	0	2,143	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	643	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	240	0		3.00
4.00	OPERATING ROOM	50.00	0	9,328	0		4.00
5.00	RECOVERY ROOM	51.00	0	38	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	118,777	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,250	0		7.00
8.00	RADIOLOGY - THERAPEUTIC	55.00	0	107	0		8.00
9.00	RADIOISOTOPE	56.00	0	66	0		9.00
10.00	LABORATORY	60.00	0	41	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	20,809	0		11.00
12.00	HYPERBARIC OXYGEN THERAPY	76.98	0	4	0		12.00
13.00	CLINIC	90.00	0	2,506	0		13.00
14.00	EMERGENCY	91.00	0	8,180	0		14.00
15.00	PHYSICIANS PRIVATE OFFICES	192.00	0	65	0		15.00
	0		0	164,197			
	D - CHARGEABLE MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	7,939	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	2,517	0		2.00
3.00	OPERATING ROOM	50.00	0	1,608,305	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	88,952	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,724	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	478,656	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	18,025	0		7.00
8.00	OCCUPATIONAL THERAPY	67.00	0	12,643	0		8.00
9.00	CENTRAL SERVICE & SUPPLY	14.00	0	1,826	0		9.00
10.00	RENAL DIALYSIS	74.00	0	22,732	0		10.00
11.00	EMERGENCY	91.00	0	158,121	0		11.00
12.00	CLINIC	90.00	0	122,176	0		12.00
	TOTALS		0	2,523,616			
	E - CAFETERIA COSTS						
1.00	DIETARY	10.00	742,574	856,632	0		1.00
	0		742,574	856,632			
	F - PHARMACY SALARIES						
1.00	PHARMACY	15.00	1,040,833	0	0		1.00
	TOTALS		1,040,833	0			
	G - RN AND AIDE WAGES						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	64,359	0	0		1.00
	TOTALS		64,359	0			
500.00	Grand Total: Decreases		1,847,766	4,129,169			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
2/28/2020 9:15 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	735,200	0	0	0	0	1.00	
2.00	Land Improvements	1,263,246	17,938	0	17,938	0	2.00	
3.00	Buildings and Fixtures	11,111,857	23,576	0	23,576	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	19,067,588	1,898,531	0	1,898,531	0	5.00	
6.00	Movable Equipment	18,559,906	2,081,240	0	2,081,240	12,570	6.00	
7.00	HIT designated Assets	702,567	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	51,440,364	4,021,285	0	4,021,285	12,570	8.00	
9.00	Reconciling Items	-1,707,052	-1,369,008	0	-1,369,008	0	9.00	
10.00	Total (line 8 minus line 9)	53,147,416	5,390,293	0	5,390,293	12,570	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	735,200	0				1.00	
2.00	Land Improvements	1,281,184	0				2.00	
3.00	Buildings and Fixtures	11,135,433	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	20,966,119	0				5.00	
6.00	Movable Equipment	20,628,576	0				6.00	
7.00	HIT designated Assets	702,567	0				7.00	
8.00	Subtotal (sum of lines 1-7)	55,449,079	0				8.00	
9.00	Reconciling Items	-3,076,060	0				9.00	
10.00	Total (line 8 minus line 9)	58,525,139	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,698,705	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,625,464	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,324,169	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	6,500	1,705,205				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,625,464				2.00
3.00	Total (sum of lines 1-2)	6,500	4,330,669				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	34,117,936	0	34,117,936	0.627242	31,202	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	21,331,143	1,055,527	20,275,616	0.372758	18,542	2.00
3.00	Total (sum of lines 1-2)	55,449,079	1,055,527	54,393,552	1.000000	49,744	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	31,202	2,402,067	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	18,542	4,224,730	0	2.00
3.00	Total (sum of lines 1-2)	0	0	49,744	6,626,797	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	470,633	31,202	0	6,500	2,910,402	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	18,542	0	0	4,243,272	2.00
3.00	Total (sum of lines 1-2)	470,633	49,744	0	6,500	7,153,674	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-64,347	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-7,623	NONPATIENT TELEPHONES	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-23,654	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-7,019,493			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	937,967			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-563,968	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	39	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-28,149	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	-16,745	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	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	TRUST ACCOUNT FEES	A	33,678	OTHER ADMIN & GENERAL	5.06	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center	Line #			
	Basis/Code (2)	Amount					
	1.00	2.00	3.00	4.00	5.00		
33.01 DOORBELL DINNERS	B	-54,126	DIETARY	10.00		0	33.01
33.02 MISC INCOME - A&G	B	-37,545	OTHER ADMIN & GENERAL	5.06		0	33.02
33.03 MISC INCOME - NURSING ADMIN	B	-15,597	NURSING ADMINISTRATION	13.00		0	33.03
33.04 MISC INCOME - OR	B	-1,218	OPERATING ROOM	50.00		0	33.04
33.05 MISC INCOME - PT	B	-77,645	PHYSICAL THERAPY	66.00		0	33.05
33.06 MISC INCOME - CLINIC	B	-13,740	CLINIC	90.00		0	33.06
33.08 RETIREE HEALTH INSURANCE PLAN	B	90,575	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.08
34.00 COMMUNITY BENEFIT SALARIES	A	-10,677	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	34.00
34.01 COMMUNITY BENEFIT SALARIES	A	-115,795	OTHER ADMIN & GENERAL	5.06		0	34.01
34.02 COMMUNITY BENEFIT BENEFITS	A	-29,114	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	34.02
34.03 COMMUNITY BENEFIT OTHER	A	-105,889	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	34.03
34.04 COMMUNITY BENEFIT OTHER	A	-33,554	OTHER ADMIN & GENERAL	5.06		0	34.04
35.00 MARKETING SALARIES	A	-56,946	OTHER ADMIN & GENERAL	5.06		0	35.00
35.01 MARKETING BENEFITS	A	-17,208	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	35.01
35.02 MARKETING OTHER	A	-219,402	OTHER ADMIN & GENERAL	5.06		0	35.02
36.00 CRNA COSTS	A	-186,443	NONPHYSICIAN ANESTHETISTS	19.00		0	36.00
36.01 LOBBYING EXPENSE	A	-23,635	OTHER ADMIN & GENERAL	5.06		0	36.01
37.00 CABLE TV	A	-6,054	OTHER ADMIN & GENERAL	5.06		0	37.00
37.02 ADVERTISING EXPENSE	A	-1,083	OTHER ADMIN & GENERAL	5.06		0	37.02
37.03 PHYSICIAN RECRUITMENT	A	-58,013	OTHER ADMIN & GENERAL	5.06		0	37.03
37.04 PROVIDER TAX	A	-3,433,114	OTHER ADMIN & GENERAL	5.06		0	37.04
37.05 LIFELINE EXPENSES	A	-43,002	OTHER ADMIN & GENERAL	5.06		0	37.05
38.00 SELF INSURANCE	A	-2,996,134	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	38.00
39.00 INTERMEDIARY DEPRECIATION ADJUSTMENT	A	30,552	CAP REL COSTS-BLDG & FIXT	1.00		9	39.00
39.01 REVALUED ASSETS DEPRECIATION ADJUSTM	A	642,503	CAP REL COSTS-BLDG & FIXT	1.00		9	39.01
39.02 REVALUED ASSETS DEPRECIATION ADJUSTM	A	881,531	CAP REL COSTS-MVBLE EQUIP	2.00		9	39.02
40.00 EMPLOYED PHYSICIAN BENEFITS	A	-94,600	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	40.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,737,668					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: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-1

Date/Time Prepared:
2/28/2020 9:15 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO NEW CAPITAL - BLDG	29,565	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO NEW CAPITAL - MME	2,253	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HO OTHER CAPITAL - BLDG	742	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO OTHER CAPITAL - MME	715,482	0	4.00
4.01	5.06	OTHER ADMIN & GENERAL	HO INTEREST OPERATING	15,124	0	4.01
4.02	7.00	OPERATION OF PLANT	HO REPAIRS & MAINTENANCE	272,143	0	4.02
4.03	5.06	OTHER ADMIN & GENERAL	HO MANAGEMENT OPERATING	2,348,034	2,445,376	4.03
4.04	0.00			0	0	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,383,343	2,445,376	5.00

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

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

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

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

6.00	B		0.00	MEMORIAL HL SYS	100.00	6.00
7.00	C		0.00	PPA	100.00	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: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-1

Date/Time Prepared:
2/28/2020 9:15 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	29,565	9		1.00
2.00	2,253	9		2.00
3.00	742	9		3.00
4.00	715,482	9		4.00
4.01	15,124	0		4.01
4.02	272,143	0		4.02
4.03	-97,342	0		4.03
4.04	0	0		4.04
5.00	937,967			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	HOME OFFICE		6.00
7.00	PHYSICIAN ORG		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: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-2

Date/Time Prepared:
2/28/2020 9:15 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	5.00	OTHER ADMIN & GENERAL	1,824,817	1,748,359	76,458	211,500	450	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,009,877	2,009,877	0	211,500	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	43,498	0	43,498	211,500	167	3.00
4.00	40.00	SUBPROVIDER - IPF	98,071	88,021	10,050	181,300	67	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	4,280	0	4,280	260,300	21	5.00
6.00	60.00	LABORATORY	75,000	75,000	0	260,300	0	6.00
7.00	65.00	RESPIRATORY THERAPY	3,187	0	3,187	260,300	13	7.00
8.00	74.00	RENAL DIALYSIS	66,887	66,887	0	211,500	0	8.00
9.00	90.00	CLINIC	1,193,058	1,191,958	1,100	211,500	6	9.00
10.00	91.00	EMERGENCY	1,830,540	1,774,261	56,279	211,500	709	10.00
200.00			7,149,215	6,954,363	194,852		1,433	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	OTHER ADMIN & GENERAL	45,757	2,288	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	16,981	849	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	5,840	292	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	2,628	131	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	1,627	81	0	0	0	7.00
8.00	74.00	RENAL DIALYSIS	0	0	0	0	0	8.00
9.00	90.00	CLINIC	610	31	0	0	0	9.00
10.00	91.00	EMERGENCY	72,093	3,605	0	0	0	10.00
200.00			145,536	7,277	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	OTHER ADMIN & GENERAL	0	45,757	30,701	1,779,060		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,009,877		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	16,981	26,517	26,517		3.00
4.00	40.00	SUBPROVIDER - IPF	0	5,840	4,210	92,231		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	2,628	1,652	1,652		5.00
6.00	60.00	LABORATORY	0	0	0	75,000		6.00
7.00	65.00	RESPIRATORY THERAPY	0	1,627	1,560	1,560		7.00
8.00	74.00	RENAL DIALYSIS	0	0	0	66,887		8.00
9.00	90.00	CLINIC	0	610	490	1,192,448		9.00
10.00	91.00	EMERGENCY	0	72,093	0	1,774,261		10.00
200.00			0	145,536	65,130	7,019,493		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,910,402	2,910,402			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,243,272	4,243,272			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,632,049	71,885	40,429	12,744,363	4.00
5.01	00540	NONPATIENT TELEPHONES	109,054	9,061	0	118,115	5.01
5.02	00550	DATA PROCESSING	2,601,379	32,442	401,933	285,580	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	450,303	83,861	0	86,175	5.03
5.04	00570	ADMITTING	772,807	11,165	788	221,925	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,443,116	21,781	0	205,418	5.05
5.06	00590	OTHER ADMIN & GENERAL	8,287,734	233,384	57,751	1,293,566	5.06
7.00	00700	OPERATION OF PLANT	4,530,840	368,935	127,322	454,627	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	357,920	60,370	10,626	75,784	8.00
9.00	00900	HOUSEKEEPING	1,311,692	116,500	47,195	334,184	9.00
10.00	01000	DIETARY	741,167	66,484	52,724	112,696	10.00
11.00	01100	CAFETERIA	1,035,238	52,065	0	221,941	11.00
13.00	01300	NURSING ADMINISTRATION	1,091,525	15,284	48,968	312,494	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	287,158	59,713	135,810	54,297	14.00
15.00	01500	PHARMACY	328,233	31,620	1,622	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	947,512	32,486	16,579	273,120	16.00
17.00	01700	SOCIAL SERVICE	421,607	6,245	0	122,583	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,807,184	265,837	260,866	1,249,117	30.00
31.00	03100	INTENSIVE CARE UNIT	1,138,543	52,569	70,929	309,396	31.00
40.00	04000	SUBPROVIDER - IPF	780,119	48,351	55,231	225,532	40.00
43.00	04300	NURSERY	443,205	8,513	0	117,073	43.00
44.00	04400	SKILLED NURSING FACILITY	1,183,201	74,011	0	320,907	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,780,583	177,550	852,279	1,048,487	50.00
51.00	05100	RECOVERY ROOM	404,432	12,918	35,007	109,747	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	110,801	17,476	0	29,268	52.00
53.00	05300	ANESTHESIOLOGY	177,239	11,384	27,818	19,236	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,087,977	34,283	331,344	488,238	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	537,350	14,211	677,420	162,812	55.00
56.00	05600	RADIOISOTOPE	550,283	3,287	0	58,291	56.00
57.00	05700	CT SCAN	927,230	71,853	33,452	161,687	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	436,023	17,476	350,178	97,212	58.00
60.00	06000	LABORATORY	4,397,166	86,534	152,487	595,518	60.00
65.00	06500	RESPIRATORY THERAPY	894,489	41,459	146,954	350,089	65.00
66.00	06600	PHYSICAL THERAPY	3,702,263	168,741	27,282	1,038,412	66.00
67.00	06700	OCCUPATIONAL THERAPY	989,914	46,171	2,141	287,655	67.00
68.00	06800	SPEECH PATHOLOGY	291,297	3,429	1,011	85,538	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,905	2,509	0	1,759	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,523,616	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,838,423	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,990,423	0	0	311,085	73.00
74.00	07400	RENAL DIALYSIS	113,730	6,618	23,962	34,314	74.00
76.00	03950	DIABETIC EDUCATION	238,588	0	492	69,897	76.00
76.97	07697	CARDIAC REHABILITATION	157,210	32,519	12,793	42,374	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	105,731	5,851	0	22,947	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,207,989	64,545	52,446	297,790	90.00
91.00	09100	EMERGENCY	4,101,294	197,162	182,861	1,002,692	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,428,216	2,738,538	4,238,700	12,591,463	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	14,112	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	481,274	0	4,572	85,952	192.00
194.00	07950	RENTED SPACE	0	150,367	0	0	194.00
194.01	07951	FUND DEVELOPMENT	310,709	7,385	0	66,948	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	89,220,199	2,910,402	4,243,272	12,744,363	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	3,328,022					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	37,394	659,166				5.03
5.04	00570	ADMITTING	224,361	15,719	1,250,945			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	224,361	40,485	0	1,937,669		5.05
5.06	00590	OTHER ADMIN & GENERAL	261,755	47,863	0	0	10,190,413	5.06
7.00	00700	OPERATION OF PLANT	0	38,878	0	0	5,526,573	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	60,062	0	0	565,240	8.00
9.00	00900	HOUSEKEEPING	0	62,123	0	0	1,872,649	9.00
10.00	01000	DIETARY	112,181	31,069	0	0	1,118,829	10.00
11.00	01100	CAFETERIA	0	103,904	0	0	1,413,148	11.00
13.00	01300	NURSING ADMINISTRATION	373,932	7,066	0	0	1,855,240	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	3,318	0	0	540,774	14.00
15.00	01500	PHARMACY	74,787	9,885	0	0	448,297	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	149,574	10,534	0	0	1,431,835	16.00
17.00	01700	SOCIAL SERVICE	37,394	635	0	0	589,897	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	74,787	22,292	56,877	88,089	6,833,648	30.00
31.00	03100	INTENSIVE CARE UNIT	224,361	3,824	16,703	25,869	1,844,224	31.00
40.00	04000	SUBPROVIDER - IPF	0	2,555	4,928	7,632	1,126,139	40.00
43.00	04300	NURSERY	0	918	4,525	7,008	581,959	43.00
44.00	04400	SKILLED NURSING FACILITY	74,787	4,702	19,184	29,712	1,708,295	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	37,394	57,518	147,928	229,106	7,344,222	50.00
51.00	05100	RECOVERY ROOM	0	991	13,230	20,490	596,815	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,041	5,319	8,238	172,979	52.00
53.00	05300	ANESTHESIOLOGY	0	2,188	19,715	30,534	291,100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	373,935	10,092	89,170	138,103	3,559,352	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	1,184	41,465	64,219	1,500,333	55.00
56.00	05600	RADIOISOTOPE	0	57	14,812	22,941	649,671	56.00
57.00	05700	CT SCAN	0	284	205,733	318,882	1,719,121	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	905	49,118	76,072	1,026,984	58.00
60.00	06000	LABORATORY	186,968	50,617	140,473	217,559	5,832,696	60.00
65.00	06500	RESPIRATORY THERAPY	112,181	27,658	70,401	109,034	1,754,415	65.00
66.00	06600	PHYSICAL THERAPY	299,148	4,288	77,482	120,001	5,445,380	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,856	21,447	33,217	1,383,476	67.00
68.00	06800	SPEECH PATHOLOGY	0	117	5,241	8,117	394,750	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	64	360	557	14,154	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	20,876	32,332	2,576,824	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	18,817	29,143	1,886,383	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	98,830	153,064	5,553,402	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,966	3,046	183,636	74.00
76.00	03950	DIABETIC EDUCATION	0	2,452	107	165	311,701	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,238	2,804	4,343	253,759	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	626	2,779	4,304	142,238	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	3,515	23,327	36,128	1,689,920	90.00
91.00	09100	EMERGENCY	299,148	16,513	77,328	119,764	6,004,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,178,448	649,036	1,250,945	1,937,669	87,935,235	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	14,112	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	149,574	1,776	0	0	726,253	192.00
194.00	07950	RENTED SPACE	0	0	0	0	150,367	194.00
194.01	07951	FUND DEVELOPMENT	0	8,354	0	0	394,232	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,328,022	659,166	1,250,945	1,937,669	89,220,199	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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Cost Center Description			OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	10,190,413					5.06
7.00	00700	OPERATION OF PLANT	712,618	6,239,191				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	72,884	181,271	819,395			8.00
9.00	00900	HOUSEKEEPING	241,467	349,811	4,877	2,468,804		9.00
10.00	01000	DIETARY	144,266	199,629	3,450	122,812	1,588,986	10.00
11.00	01100	CAFETERIA	182,217	156,334	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	239,222	45,894	0	61,322	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	69,730	179,297	0	4,368	0	14.00
15.00	01500	PHARMACY	57,805	94,945	0	45,992	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	184,627	97,544	0	19,783	0	16.00
17.00	01700	SOCIAL SERVICE	76,064	18,752	0	4,368	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	881,158	798,220	163,625	670,049	987,020	30.00
31.00	03100	INTENSIVE CARE UNIT	237,802	157,848	0	61,322	68,196	31.00
40.00	04000	SUBPROVIDER - IPF	145,209	145,182	2,694	0	92,527	40.00
43.00	04300	NURSERY	75,040	25,562	4,608	36,121	0	43.00
44.00	04400	SKILLED NURSING FACILITY	220,274	222,230	115,000	107,314	441,243	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	946,988	533,122	137,696	229,202	0	50.00
51.00	05100	RECOVERY ROOM	76,956	38,787	4,493	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,305	52,473	5,226	40,951	0	52.00
53.00	05300	ANESTHESIOLOGY	37,536	34,182	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	458,957	102,940	98,978	94,839	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	193,459	42,670	6,175	44,018	0	55.00
56.00	05600	RADIOISOTOPE	83,771	9,870	0	0	0	56.00
57.00	05700	CT SCAN	221,670	215,749	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	132,423	52,473	0	0	0	58.00
60.00	06000	LABORATORY	752,091	259,833	584	68,378	0	60.00
65.00	06500	RESPIRATORY THERAPY	226,221	124,488	2,693	44,018	0	65.00
66.00	06600	PHYSICAL THERAPY	702,149	506,672	80,720	190,687	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	178,391	138,635	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	50,901	10,297	0	33,013	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,825	7,534	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	332,266	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	243,238	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	716,078	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	23,679	19,871	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	40,192	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	32,721	97,643	378	23,227	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	18,341	17,568	1,537	16,675	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	217,905	193,806	162	114,370	0	90.00
91.00	09100	EMERGENCY	774,278	592,011	179,359	432,069	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,024,724	5,723,143	812,255	2,464,898	1,588,986	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,820	42,373	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	93,646	0	7,140	3,906	0	192.00
194.00	07950	RENTED SPACE	19,389	451,501	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	50,834	22,174	0	0	0	194.01
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)	10,190,413	6,239,191	819,395	2,468,804	1,588,986	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & 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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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	1,751,699					11.00
13.00	01300	NURSING ADMINISTRATION	49,717	2,251,395				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	18,191	0	812,360			14.00
15.00	01500	PHARMACY	0	0	0	647,039		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	69,410	0	0	0	1,803,199	16.00
17.00	01700	SOCIAL SERVICE	21,459	79,905	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	238,539	1,013,502	0	326	81,983	30.00
31.00	03100	INTENSIVE CARE UNIT	54,593	220,399	0	98	24,076	31.00
40.00	04000	SUBPROVIDER - IPF	37,043	157,492	0	0	7,103	40.00
43.00	04300	NURSERY	17,182	72,437	0	0	6,523	43.00
44.00	04400	SKILLED NURSING FACILITY	76,924	327,429	0	36	27,653	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	186,666	0	0	5,763	213,227	50.00
51.00	05100	RECOVERY ROOM	15,763	0	0	6	19,070	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,483	82,162	0	0	7,667	52.00
53.00	05300	ANESTHESIOLOGY	6,915	0	0	18,592	28,418	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,170	0	0	649	128,531	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	21,532	0	0	16	59,768	55.00
56.00	05600	RADIOISOTOPE	7,398	0	0	17	21,351	56.00
57.00	05700	CT SCAN	26,524	0	0	13,205	296,611	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,558	0	0	2,918	70,799	58.00
60.00	06000	LABORATORY	139,398	0	0	6	202,480	60.00
65.00	06500	RESPIRATORY THERAPY	71,491	298,069	0	3,164	101,477	65.00
66.00	06600	PHYSICAL THERAPY	167,183	0	0	0	111,683	66.00
67.00	06700	OCCUPATIONAL THERAPY	37,411	0	0	0	30,914	67.00
68.00	06800	SPEECH PATHOLOGY	10,004	0	0	0	7,555	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	357	0	0	0	518	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	469,983	0	30,091	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	342,377	0	27,123	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,352	0	0	600,464	142,455	73.00
74.00	07400	RENAL DIALYSIS	3,573	0	0	0	2,834	74.00
76.00	03950	DIABETIC EDUCATION	22,772	0	0	0	154	76.00
76.97	07697	CARDIAC REHABILITATION	7,913	0	0	0	4,042	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,203	0	0	1	4,006	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	51,125	0	0	390	33,624	90.00
91.00	09100	EMERGENCY	190,670	0	0	1,378	111,463	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,720,519	2,251,395	812,360	647,029	1,803,199	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	13,672	0	0	10	0	192.00
194.00	07950	RENTED SPACE	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	17,508	0	0	0	0	194.01
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)	1,751,699	2,251,395	812,360	647,039	1,803,199	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0058

Period:
From 10/01/2018
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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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 SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	790,445					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	415,416	0	12,083,486	0	12,083,486	30.00
31.00	03100	INTENSIVE CARE UNIT	52,747	0	2,721,305	0	2,721,305	31.00
40.00	04000	SUBPROVIDER - IPF	41,905	0	1,755,294	0	1,755,294	40.00
43.00	04300	NURSERY	40,007	0	859,439	0	859,439	43.00
44.00	04400	SKILLED NURSING FACILITY	240,370	0	3,486,768	0	3,486,768	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	9,596,886	0	9,596,886	50.00
51.00	05100	RECOVERY ROOM	0	0	751,890	0	751,890	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	403,246	0	403,246	52.00
53.00	05300	ANESTHESIOLOGY	0	0	416,743	0	416,743	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,531,416	0	4,531,416	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	1,867,971	0	1,867,971	55.00
56.00	05600	RADIOISOTOPE	0	0	772,078	0	772,078	56.00
57.00	05700	CT SCAN	0	0	2,492,880	0	2,492,880	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,304,155	0	1,304,155	58.00
60.00	06000	LABORATORY	0	0	7,255,466	0	7,255,466	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,626,036	0	2,626,036	65.00
66.00	06600	PHYSICAL THERAPY	0	0	7,204,474	0	7,204,474	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,768,827	0	1,768,827	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	506,520	0	506,520	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	24,388	0	24,388	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3,409,164	0	3,409,164	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,499,121	0	2,499,121	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,053,751	0	7,053,751	73.00
74.00	07400	RENAL DIALYSIS	0	0	233,593	0	233,593	74.00
76.00	03950	DIABETIC EDUCATION	0	0	374,819	0	374,819	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	419,683	0	419,683	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	204,569	0	204,569	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	2,301,302	0	2,301,302	90.00
91.00	09100	EMERGENCY	0	0	8,285,992	0	8,285,992	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	790,445	0	87,211,262	0	87,211,262	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	58,305	0	58,305	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	844,627	0	844,627	192.00
194.00	07950	RENTED SPACE	0	0	621,257	0	621,257	194.00
194.01	07951	FUND DEVELOPMENT	0	0	484,748	0	484,748	194.01
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	790,445	0	89,220,199	0	89,220,199	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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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	71,885	40,429	112,314	4.00
5.01	00540	NONPATIENT TELEPHONES	0	9,061	0	9,061	5.01
5.02	00550	DATA PROCESSING	2,118	32,442	401,933	436,493	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	83,861	0	83,861	5.03
5.04	00570	ADMITTING	0	11,165	788	11,953	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,880	21,781	0	24,661	5.05
5.06	00590	OTHER ADMIN & GENERAL	0	233,384	57,751	291,135	5.06
7.00	00700	OPERATION OF PLANT	2,277	368,935	127,322	498,534	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	60,370	10,626	70,996	8.00
9.00	00900	HOUSEKEEPING	0	116,500	47,195	163,695	9.00
10.00	01000	DIETARY	0	66,484	52,724	119,208	10.00
11.00	01100	CAFETERIA	0	52,065	0	52,065	11.00
13.00	01300	NURSING ADMINISTRATION	0	15,284	48,968	64,252	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	59,713	135,810	195,523	14.00
15.00	01500	PHARMACY	33,475	31,620	1,622	66,717	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	32,486	16,579	49,065	16.00
17.00	01700	SOCIAL SERVICE	0	6,245	0	6,245	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	61,635	265,837	260,866	588,338	30.00
31.00	03100	INTENSIVE CARE UNIT	13,953	52,569	70,929	137,451	31.00
40.00	04000	SUBPROVIDER - IPF	12,714	48,351	55,231	116,296	40.00
43.00	04300	NURSERY	0	8,513	0	8,513	43.00
44.00	04400	SKILLED NURSING FACILITY	30,888	74,011	0	104,899	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	50,659	177,550	852,279	1,080,488	50.00
51.00	05100	RECOVERY ROOM	12,883	12,918	35,007	60,808	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,476	0	17,476	52.00
53.00	05300	ANESTHESIOLOGY	13,592	11,384	27,818	52,794	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,283	331,344	365,627	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	14,211	677,420	691,631	55.00
56.00	05600	RADIOISOTOPE	0	3,287	0	3,287	56.00
57.00	05700	CT SCAN	0	71,853	33,452	105,305	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	17,476	350,178	367,654	58.00
60.00	06000	LABORATORY	332	86,534	152,487	239,353	60.00
65.00	06500	RESPIRATORY THERAPY	1,077	41,459	146,954	189,490	65.00
66.00	06600	PHYSICAL THERAPY	139,870	168,741	27,282	335,893	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	46,171	2,141	48,312	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,429	1,011	4,440	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,509	0	2,509	70.00
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	6,618	23,962	30,580	74.00
76.00	03950	DIABETIC EDUCATION	0	0	492	492	76.00
76.97	07697	CARDIAC REHABILITATION	332	32,519	12,793	45,644	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	5,851	0	5,851	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,213	64,545	52,446	122,204	90.00
91.00	09100	EMERGENCY	31,398	197,162	182,861	411,421	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	415,296	2,738,538	4,238,700	7,392,534	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	14,112	0	14,112	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	24,055	0	4,572	28,627	192.00
194.00	07950	RENTED SPACE	0	150,367	0	150,367	194.00
194.01	07951	FUND DEVELOPMENT	0	7,385	0	7,385	194.01
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)	439,351	2,910,402	4,243,272	7,593,025	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0058

Period:
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Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	9,061					5.01
5.02	00550	DATA PROCESSING	513	439,523				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	110	4,938	89,668			5.03
5.04	00570	ADMITTING	321	29,631	2,138	45,999		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	192	29,631	5,507	0	61,801	5.05
5.06	00590	OTHER ADMIN & GENERAL	641	34,569	6,511	0	0	5.06
7.00	00700	OPERATION OF PLANT	458	0	5,289	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	37	0	8,170	0	0	8.00
9.00	00900	HOUSEKEEPING	73	0	8,451	0	0	9.00
10.00	01000	DIETARY	192	14,815	4,226	0	0	10.00
11.00	01100	CAFETERIA	0	0	14,134	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	458	49,385	961	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	37	0	451	0	0	14.00
15.00	01500	PHARMACY	165	9,877	1,345	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	156	19,754	1,433	0	0	16.00
17.00	01700	SOCIAL SERVICE	110	4,938	86	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	660	9,877	3,032	2,089	2,810	30.00
31.00	03100	INTENSIVE CARE UNIT	156	29,631	520	614	825	31.00
40.00	04000	SUBPROVIDER - IPF	137	0	348	181	243	40.00
43.00	04300	NURSERY	55	0	125	166	224	43.00
44.00	04400	SKILLED NURSING FACILITY	137	9,877	640	705	948	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,027	4,938	7,824	5,434	7,307	50.00
51.00	05100	RECOVERY ROOM	0	0	135	486	654	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	64	0	142	195	263	52.00
53.00	05300	ANESTHESIOLOGY	229	0	298	724	974	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	476	49,385	1,373	3,275	4,405	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	128	0	161	1,523	2,048	55.00
56.00	05600	RADIOISOTOPE	0	0	8	544	732	56.00
57.00	05700	CT SCAN	0	0	39	7,607	10,169	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	123	1,804	2,426	58.00
60.00	06000	LABORATORY	412	24,692	6,886	5,160	6,939	60.00
65.00	06500	RESPIRATORY THERAPY	165	14,815	3,762	2,586	3,478	65.00
66.00	06600	PHYSICAL THERAPY	596	39,508	583	2,846	3,827	66.00
67.00	06700	OCCUPATIONAL THERAPY	82	0	253	788	1,059	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	16	193	259	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	9	13	18	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	767	1,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	691	930	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,630	4,882	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	72	97	74.00
76.00	03950	DIABETIC EDUCATION	0	0	334	4	5	76.00
76.97	07697	CARDIAC REHABILITATION	37	0	168	103	139	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	85	102	137	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	321	0	478	857	1,152	90.00
91.00	09100	EMERGENCY	614	39,508	2,246	2,840	3,820	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,759	419,769	88,290	45,999	61,801	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	238	19,754	242	0	0	192.00
194.00	07950	RENTED SPACE	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	64	0	1,136	0	0	194.01
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)	9,061	439,523	89,668	45,999	61,801	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0058

Period:
From 10/01/2018
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Part II
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Cost Center Description			OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	344,255					5.06
7.00	00700	OPERATION OF PLANT	24,074	532,362				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,462	15,467	97,800			8.00
9.00	00900	HOUSEKEEPING	8,157	29,848	582	213,751		9.00
10.00	01000	DIETARY	4,874	17,033	412	10,633	172,386	10.00
11.00	01100	CAFETERIA	6,156	13,339	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,081	3,916	0	5,309	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	2,356	15,299	0	378	0	14.00
15.00	01500	PHARMACY	1,953	8,101	0	3,982	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,237	8,323	0	1,713	0	16.00
17.00	01700	SOCIAL SERVICE	2,570	1,600	0	378	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,767	68,108	19,530	58,016	107,080	30.00
31.00	03100	INTENSIVE CARE UNIT	8,033	13,468	0	5,309	7,398	31.00
40.00	04000	SUBPROVIDER - IPF	4,905	12,388	322	0	10,038	40.00
43.00	04300	NURSERY	2,535	2,181	550	3,127	0	43.00
44.00	04400	SKILLED NURSING FACILITY	7,441	18,962	13,726	9,291	47,870	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,993	45,489	16,435	19,844	0	50.00
51.00	05100	RECOVERY ROOM	2,600	3,310	536	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	753	4,477	624	3,546	0	52.00
53.00	05300	ANESTHESIOLOGY	1,268	2,917	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,505	8,783	11,814	8,211	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	6,535	3,641	737	3,811	0	55.00
56.00	05600	RADIOISOTOPE	2,830	842	0	0	0	56.00
57.00	05700	CT SCAN	7,488	18,409	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,474	4,477	0	0	0	58.00
60.00	06000	LABORATORY	25,407	22,170	70	5,920	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,642	10,622	321	3,811	0	65.00
66.00	06600	PHYSICAL THERAPY	23,720	43,232	9,634	16,510	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,026	11,829	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,720	879	0	2,858	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	62	643	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,225	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,217	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,191	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	800	1,695	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	1,358	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,105	8,331	45	2,011	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	620	1,499	183	1,444	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7,361	16,537	19	9,902	0	90.00
91.00	09100	EMERGENCY	26,157	50,514	21,408	37,409	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	338,658	488,329	96,948	213,413	172,386	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	61	3,616	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,164	0	852	338	0	192.00
194.00	07950	RENTED SPACE	655	38,525	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	1,717	1,892	0	0	0	194.01
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)	344,255	532,362	97,800	213,751	172,386	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & 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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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	87,650					11.00
13.00	01300	NURSING ADMINISTRATION	2,488	137,604				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	910	0	215,433			14.00
15.00	01500	PHARMACY	0	0	0	92,140		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,473	0	0	0	92,561	16.00
17.00	01700	SOCIAL SERVICE	1,074	4,884	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,935	61,944	0	46	4,214	30.00
31.00	03100	INTENSIVE CARE UNIT	2,732	13,471	0	14	1,238	31.00
40.00	04000	SUBPROVIDER - IPF	1,854	9,626	0	0	365	40.00
43.00	04300	NURSERY	860	4,427	0	0	335	43.00
44.00	04400	SKILLED NURSING FACILITY	3,849	20,012	0	5	1,422	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,340	0	0	821	10,961	50.00
51.00	05100	RECOVERY ROOM	789	0	0	1	980	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	975	5,022	0	0	394	52.00
53.00	05300	ANESTHESIOLOGY	346	0	0	2,648	1,461	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,362	0	0	92	6,607	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,077	0	0	2	3,072	55.00
56.00	05600	RADIOISOTOPE	370	0	0	2	1,098	56.00
57.00	05700	CT SCAN	1,327	0	0	1,880	15,114	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	929	0	0	416	3,639	58.00
60.00	06000	LABORATORY	6,975	0	0	1	10,409	60.00
65.00	06500	RESPIRATORY THERAPY	3,577	18,218	0	451	5,217	65.00
66.00	06600	PHYSICAL THERAPY	8,365	0	0	0	5,741	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,872	0	0	0	1,589	67.00
68.00	06800	SPEECH PATHOLOGY	501	0	0	501	388	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	18	0	0	0	27	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	124,637	0	1,547	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	90,796	0	1,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,069	0	0	85,508	7,323	73.00
74.00	07400	RENAL DIALYSIS	179	0	0	0	146	74.00
76.00	03950	DIABETIC EDUCATION	1,139	0	0	0	8	76.00
76.97	07697	CARDIAC REHABILITATION	396	0	0	0	208	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	210	0	0	0	206	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,558	0	0	56	1,728	90.00
91.00	09100	EMERGENCY	9,541	0	0	196	5,730	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,090	137,604	215,433	92,139	92,561	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	684	0	0	1	0	192.00
194.00	07950	RENTED SPACE	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	876	0	0	0	0	194.01
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)	87,650	137,604	215,433	92,140	92,561	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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 SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	22,965					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,070		990,524	0	990,524	30.00
31.00	03100	INTENSIVE CARE UNIT	1,532		225,119	0	225,119	31.00
40.00	04000	SUBPROVIDER - IPF	1,217		159,908	0	159,908	40.00
43.00	04300	NURSERY	1,162		25,292	0	25,292	43.00
44.00	04400	SKILLED NURSING FACILITY	6,984		249,596	0	249,596	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		1,251,141	0	1,251,141	50.00
51.00	05100	RECOVERY ROOM	0		71,266	0	71,266	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		34,189	0	34,189	52.00
53.00	05300	ANESTHESIOLOGY	0		63,829	0	63,829	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		484,218	0	484,218	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0		715,801	0	715,801	55.00
56.00	05600	RADIOISOTOPE	0		10,227	0	10,227	56.00
57.00	05700	CT SCAN	0		168,763	0	168,763	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		386,799	0	386,799	58.00
60.00	06000	LABORATORY	0		359,642	0	359,642	60.00
65.00	06500	RESPIRATORY THERAPY	0		267,240	0	267,240	65.00
66.00	06600	PHYSICAL THERAPY	0		499,606	0	499,606	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		74,345	0	74,345	67.00
68.00	06800	SPEECH PATHOLOGY	0		12,008	0	12,008	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		3,315	0	3,315	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		139,207	0	139,207	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		102,028	0	102,028	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		130,345	0	130,345	73.00
74.00	07400	RENAL DIALYSIS	0		33,871	0	33,871	74.00
76.00	03950	DIABETIC EDUCATION	0		3,956	0	3,956	76.00
76.97	07697	CARDIAC REHABILITATION	0		58,560	0	58,560	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		10,539	0	10,539	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		165,797	0	165,797	90.00
91.00	09100	EMERGENCY	0		620,241	0	620,241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,965	0	7,317,372	0	7,317,372	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		17,789	0	17,789	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		54,657	0	54,657	192.00
194.00	07950	RENTED SPACE	0		189,547	0	189,547	194.00
194.01	07951	FUND DEVELOPMENT	0		13,660	0	13,660	194.01
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	22,965	0	7,593,025	0	7,593,025	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (DEPT TIME)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	265,633				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,139,476			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,561	29,912	42,640,190		4.00
5.01	00540	NONPATIENT TELEPHONES	827	0	0	989	5.01
5.02	00550	DATA PROCESSING	2,961	297,379	955,499	56	24,475
5.03	00560	PURCHASING RECEIVING AND STORES	7,654	0	288,326	12	275
5.04	00570	ADMITTING	1,019	583	742,519	35	1,650
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,988	0	687,290	21	1,650
5.06	00590	OTHER ADMIN & GENERAL	21,301	42,728	4,327,949	70	1,925
7.00	00700	OPERATION OF PLANT	33,673	94,202	1,521,097	50	0
8.00	00800	LAUNDRY & LINEN SERVICE	5,510	7,862	253,560	4	0
9.00	00900	HOUSEKEEPING	10,633	34,918	1,118,116	8	0
10.00	01000	DIETARY	6,068	39,009	377,061	21	825
11.00	01100	CAFETERIA	4,752	0	742,574	0	0
13.00	01300	NURSING ADMINISTRATION	1,395	36,230	1,045,547	50	2,750
14.00	01400	CENTRAL SERVICE & SUPPLY	5,450	100,482	181,666	4	0
15.00	01500	PHARMACY	2,886	1,200	0	18	550
16.00	01600	MEDICAL RECORDS & LIBRARY	2,965	12,266	913,810	17	1,100
17.00	01700	SOCIAL SERVICE	570	0	410,141	12	275
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	24,263	193,007	4,179,311	72	550
31.00	03100	INTENSIVE CARE UNIT	4,798	52,478	1,035,182	17	1,650
40.00	04000	SUBPROVIDER - IPF	4,413	40,864	754,588	15	0
43.00	04300	NURSERY	777	0	391,705	6	0
44.00	04400	SKILLED NURSING FACILITY	6,755	0	1,073,696	15	550
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,205	630,577	3,508,040	112	275
51.00	05100	RECOVERY ROOM	1,179	25,901	367,193	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,595	0	97,926	7	0
53.00	05300	ANESTHESIOLOGY	1,039	20,582	64,359	25	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,129	245,152	1,633,554	52	2,750
55.00	05500	RADIOLOGY - THERAPEUTIC	1,297	501,204	544,740	14	0
56.00	05600	RADIOISOTOPE	300	0	195,032	0	0
57.00	05700	CT SCAN	6,558	24,750	540,976	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,595	259,087	325,252	0	0
60.00	06000	LABORATORY	7,898	112,821	1,992,492	45	1,375
65.00	06500	RESPIRATORY THERAPY	3,784	108,727	1,171,334	18	825
66.00	06600	PHYSICAL THERAPY	15,401	20,185	3,474,334	65	2,200
67.00	06700	OCCUPATIONAL THERAPY	4,214	1,584	962,441	9	0
68.00	06800	SPEECH PATHOLOGY	313	748	286,194	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	229	0	5,885	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,040,833	0	0
74.00	07400	RENAL DIALYSIS	604	17,729	114,809	0	0
76.00	03950	DIABETIC EDUCATION	0	364	233,862	0	0
76.97	07697	CARDIAC REHABILITATION	2,968	9,465	141,774	4	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	534	0	76,777	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,891	38,803	996,351	35	0
91.00	09100	EMERGENCY	17,995	135,294	3,354,820	67	2,200
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	249,947	3,136,093	42,128,615	956	23,375
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,288	0	0	0	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	3,383	287,581	26	1,100
194.00	07950	RENTED SPACE	13,724	0	0	0	0
194.01	07951	FUND DEVELOPMENT	674	0	223,994	7	0
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)	2,910,402	4,243,272	12,744,363	118,115	3,328,022
203.00		Unit cost multiplier (Wkst. B, Part I)	10.956478	1.351586	0.298881	119.428716	135.976384
204.00		Cost to be allocated (per Wkst. B, Part II)			112,314	9,061	439,523

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (DEPT TIME)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002634	9.161780	17.958039	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: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description			PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,012,778					5.03
5.04	00570	ADMITTING	24,152	396,155,126				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	62,204	0	396,155,126			5.05
5.06	00590	OTHER ADMIN & GENERAL	73,539	0	0	-10,190,413	79,029,786	5.06
7.00	00700	OPERATION OF PLANT	59,734	0	0	0	5,526,573	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	92,283	0	0	0	565,240	8.00
9.00	00900	HOUSEKEEPING	95,449	0	0	0	1,872,649	9.00
10.00	01000	DIETARY	47,736	0	0	0	1,118,829	10.00
11.00	01100	CAFETERIA	159,640	0	0	0	1,413,148	11.00
13.00	01300	NURSING ADMINISTRATION	10,857	0	0	0	1,855,240	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	5,098	0	0	0	540,774	14.00
15.00	01500	PHARMACY	15,188	0	0	0	448,297	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,185	0	0	0	1,431,835	16.00
17.00	01700	SOCIAL SERVICE	975	0	0	0	589,897	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,251	18,010,422	18,010,422	0	6,833,648	30.00
31.00	03100	INTENSIVE CARE UNIT	5,876	5,289,041	5,289,041	0	1,844,224	31.00
40.00	04000	SUBPROVIDER - IPF	3,925	1,560,351	1,560,351	0	1,126,139	40.00
43.00	04300	NURSE	1,410	1,432,898	1,432,898	0	581,959	43.00
44.00	04400	SKILLED NURSING FACILITY	7,225	6,074,805	6,074,805	0	1,708,295	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	88,374	46,842,387	46,842,387	0	7,344,222	50.00
51.00	05100	RECOVERY ROOM	1,523	4,189,340	4,189,340	0	596,815	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,599	1,684,218	1,684,218	0	172,979	52.00
53.00	05300	ANESTHESIOLOGY	3,361	6,242,972	6,242,972	0	291,100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,506	28,236,165	28,236,165	0	3,559,352	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,819	13,130,042	13,130,042	0	1,500,333	55.00
56.00	05600	RADIOISOTOPE	88	4,690,361	4,690,361	0	649,671	56.00
57.00	05700	CT SCAN	437	65,182,711	65,182,711	0	1,719,121	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,391	15,553,368	15,553,368	0	1,026,984	58.00
60.00	06000	LABORATORY	77,771	44,481,517	44,481,517	0	5,832,696	60.00
65.00	06500	RESPIRATORY THERAPY	42,496	22,292,778	22,292,778	0	1,754,415	65.00
66.00	06600	PHYSICAL THERAPY	6,589	24,535,032	24,535,032	0	5,445,380	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,852	6,791,359	6,791,359	0	1,383,476	67.00
68.00	06800	SPEECH PATHOLOGY	179	1,659,679	1,659,679	0	394,750	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	99	113,853	113,853	0	14,154	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,610,580	6,610,580	0	2,576,824	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,958,540	5,958,540	0	1,886,383	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	31,295,025	31,295,025	0	5,553,402	73.00
74.00	07400	RENAL DIALYSIS	0	622,689	622,689	0	183,636	74.00
76.00	03950	DIABETIC EDUCATION	3,767	33,773	33,773	0	311,701	76.00
76.97	07697	CARDIAC REHABILITATION	1,902	887,952	887,952	0	253,759	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	962	880,069	880,069	0	142,238	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,400	7,386,675	7,386,675	0	1,689,920	90.00
91.00	09100	EMERGENCY	25,372	24,486,524	24,486,524	0	6,004,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	997,214	396,155,126	396,155,126	-10,190,413	77,744,822	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	14,112	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,729	0	0	0	726,253	192.00
194.00	07950	RENTED SPACE	0	0	0	0	150,367	194.00
194.01	07951	FUND DEVELOPMENT	12,835	0	0	0	394,232	194.01
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)	659,166	1,250,945	1,937,669		10,190,413	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.650849	0.003158	0.004891		0.128944	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	89,668	45,999	61,801		344,255	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.088537	0.000116	0.000156		0.004356	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description		PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
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: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		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
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMIN & GENERAL					5.06
7.00	00700	OPERATION OF PLANT	189,649				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,510	855,188			8.00
9.00	00900	HOUSEKEEPING	10,633	5,090	58,779		9.00
10.00	01000	DIETARY	6,068	3,601	2,924	45,389	10.00
11.00	01100	CAFETERIA	4,752	0	0	166,690	11.00
13.00	01300	NURSING ADMINISTRATION	1,395	0	1,460	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	5,450	0	104	0	14.00
15.00	01500	PHARMACY	2,886	0	1,095	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,965	0	471	0	16.00
17.00	01700	SOCIAL SERVICE	570	0	104	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	24,263	170,772	15,953	28,194	30.00
31.00	03100	INTENSIVE CARE UNIT	4,798	0	1,460	1,948	31.00
40.00	04000	SUBPROVIDER - IPF	4,413	2,812	0	2,643	40.00
43.00	04300	NURSERY	777	4,809	860	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,755	120,023	2,555	12,604	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,205	143,711	5,457	0	50.00
51.00	05100	RECOVERY ROOM	1,179	4,689	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,595	5,454	975	0	52.00
53.00	05300	ANESTHESIOLOGY	1,039	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,129	103,302	2,258	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,297	6,445	1,048	0	55.00
56.00	05600	RADIOISOTOPE	300	0	0	0	56.00
57.00	05700	CT SCAN	6,558	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,595	0	0	0	58.00
60.00	06000	LABORATORY	7,898	609	1,628	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,784	2,811	1,048	0	65.00
66.00	06600	PHYSICAL THERAPY	15,401	84,246	4,540	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,214	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	313	0	786	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	229	0	0	0	70.00
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	604	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,968	394	553	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	534	1,604	397	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,891	169	2,723	0	90.00
91.00	09100	EMERGENCY	17,995	187,195	10,287	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	173,963	847,736	58,686	45,389	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,288	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	7,452	93	0	192.00
194.00	07950	RENTED SPACE	13,724	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	674	0	0	0	194.01
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)	6,239,191	819,395	2,468,804	1,588,986	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.898623	0.958146	42.001463	35.008174	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	532,362	97,800	213,751	172,386	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.807091	0.114361	3.636520	3.797969	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
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: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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	301,202					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	4,362,039				14.00
15.00	01500	PHARMACY	0	0	4,255,898			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	396,155,126		16.00
17.00	01700	SOCIAL SERVICE	10,690	0	0	0	14,581	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	135,591	0	2,143	18,010,422	7,663	30.00
31.00	03100	INTENSIVE CARE UNIT	29,486	0	643	5,289,041	973	31.00
40.00	04000	SUBPROVIDER - IPF	21,070	0	0	1,560,351	773	40.00
43.00	04300	NURSERY	9,691	0	0	1,432,898	738	43.00
44.00	04400	SKILLED NURSING FACILITY	43,805	0	240	6,074,805	4,434	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	37,907	46,842,387	0	50.00
51.00	05100	RECOVERY ROOM	0	0	38	4,189,340	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,992	0	0	1,684,218	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	122,290	6,242,972	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,270	28,236,165	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	107	13,130,042	0	55.00
56.00	05600	RADIOISOTOPE	0	0	110	4,690,361	0	56.00
57.00	05700	CT SCAN	0	0	86,859	65,182,711	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	19,192	15,553,368	0	58.00
60.00	06000	LABORATORY	0	0	41	44,481,517	0	60.00
65.00	06500	RESPIRATORY THERAPY	39,877	0	20,809	22,292,778	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	24,535,032	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,791,359	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,659,679	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	113,853	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,523,616	0	6,610,580	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,838,423	0	5,958,540	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,949,551	31,295,025	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	622,689	0	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	33,773	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	887,952	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	4	880,069	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	2,567	7,386,675	0	90.00
91.00	09100	EMERGENCY	0	0	9,062	24,486,524	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	301,202	4,362,039	4,255,833	396,155,126	14,581	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	65	0	0	192.00
194.00	07950	RENTED SPACE	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0	0	194.01
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)	2,251,395	812,360	647,039	1,803,199	790,445	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.474701	0.186234	0.152033	0.004552	54.210617	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	137,604	215,433	92,140	92,561	22,965	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.456850	0.049388	0.021650	0.000234	1.574995	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	13.00	14.00	15.00	16.00	17.00	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet B-1
Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	5.03
5.04	00570	ADMITTING	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.05
5.06	00590	OTHER ADMIN & GENERAL	5.06
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 SERVICE & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
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	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	DIABETIC EDUCATION	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
194.00	07950	RENTED SPACE	194.00
194.01	07951	FUND DEVELOPMENT	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
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

MCRIF32 - 15.11.167.2

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 9:15 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	16,060,854		16,060,854		30.00
31.00	03100	INTENSIVE CARE UNIT	5,289,041		5,289,041		31.00
40.00	04000	SUBPROVIDER - IPF	1,560,351		1,560,351		40.00
43.00	04300	NURSERY	1,432,898		1,432,898		43.00
44.00	04400	SKILLED NURSING FACILITY	6,074,805		6,074,805		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,639,072	37,203,315	46,842,387	0.204876	0.000000
51.00	05100	RECOVERY ROOM	909,874	3,279,465	4,189,339	0.179477	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,293,441	390,777	1,684,218	0.239426	0.000000
53.00	05300	ANESTHESIOLOGY	1,362,150	4,880,822	6,242,972	0.066754	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,271,230	25,964,935	28,236,165	0.160483	0.000000
55.00	05500	RADIOLOGY - THERAPEUTIC	5,922	13,124,120	13,130,042	0.142267	0.000000
56.00	05600	RADIOISOTOPE	201,541	4,488,820	4,690,361	0.164610	0.000000
57.00	05700	CT SCAN	6,539,671	58,643,040	65,182,711	0.038244	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	789,377	14,763,991	15,553,368	0.083850	0.000000
60.00	06000	LABORATORY	13,900,383	30,581,134	44,481,517	0.163112	0.000000
65.00	06500	RESPIRATORY THERAPY	9,756,362	12,536,416	22,292,778	0.117798	0.000000
66.00	06600	PHYSICAL THERAPY	2,642,482	21,892,550	24,535,032	0.293640	0.000000
67.00	06700	OCCUPATIONAL THERAPY	2,342,630	4,448,728	6,791,358	0.260453	0.000000
68.00	06800	SPEECH PATHOLOGY	286,543	1,373,136	1,659,679	0.305192	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	1,498	112,355	113,853	0.214206	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,717,974	3,892,606	6,610,580	0.515713	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,494,288	3,464,251	5,958,539	0.419418	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	12,461,625	18,833,400	31,295,025	0.225395	0.000000
74.00	07400	RENAL DIALYSIS	622,689	0	622,689	0.375136	0.000000
76.00	03950	DIABETIC EDUCATION	0	33,773	33,773	11.098185	0.000000
76.97	07697	CARDIAC REHABILITATION	551	887,401	887,952	0.472642	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	880,069	880,069	0.232447	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	450,457	6,936,218	7,386,675	0.311548	0.000000
91.00	09100	EMERGENCY	3,894,380	20,592,145	24,486,525	0.338390	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	272,780	1,676,788	1,949,568	0.834498	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	105,274,869	290,880,255	396,155,124		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	105,274,869	290,880,255	396,155,124		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.204876		50.00
51.00	05100	RECOVERY ROOM	0.179477		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.239426		52.00
53.00	05300	ANESTHESIOLOGY	0.066754		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.160541		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.142267		55.00
56.00	05600	RADIOISOTOPE	0.164610		56.00
57.00	05700	CT SCAN	0.038244		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.083850		58.00
60.00	06000	LABORATORY	0.163112		60.00
65.00	06500	RESPIRATORY THERAPY	0.117868		65.00
66.00	06600	PHYSICAL THERAPY	0.293640		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.260453		67.00
68.00	06800	SPEECH PATHOLOGY	0.305192		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.214206		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.515713		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.419418		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225395		73.00
74.00	07400	RENAL DIALYSIS	0.375136		74.00
76.00	03950	DIABETIC EDUCATION	11.098185		76.00
76.97	07697	CARDIAC REHABILITATION	0.472642		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.232447		76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.311614		90.00
91.00	09100	EMERGENCY	0.338390		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.834498		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 9:15 am

				Title XIX		Hospital			
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE	Total Costs		
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	12,083,486		12,083,486	0	12,083,486	30.00	
31.00	03100	INTENSIVE CARE UNIT	2,721,305		2,721,305	26,517	2,747,822	31.00	
40.00	04000	SUBPROVIDER - IPF	1,755,294		1,755,294	4,210	1,759,504	40.00	
43.00	04300	NURSERY	859,439		859,439	0	859,439	43.00	
44.00	04400	SKILLED NURSING FACILITY	3,486,768		3,486,768	0	3,486,768	44.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	9,596,886		9,596,886	0	9,596,886	50.00	
51.00	05100	RECOVERY ROOM	751,890		751,890	0	751,890	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	403,246		403,246	0	403,246	52.00	
53.00	05300	ANESTHESIOLOGY	416,743		416,743	0	416,743	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,531,416		4,531,416	1,652	4,533,068	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	1,867,971		1,867,971	0	1,867,971	55.00	
56.00	05600	RADIOISOTOPE	772,078		772,078	0	772,078	56.00	
57.00	05700	CT SCAN	2,492,880		2,492,880	0	2,492,880	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,304,155		1,304,155	0	1,304,155	58.00	
60.00	06000	LABORATORY	7,255,466		7,255,466	0	7,255,466	60.00	
65.00	06500	RESPIRATORY THERAPY	2,626,036	0	2,626,036	1,560	2,627,596	65.00	
66.00	06600	PHYSICAL THERAPY	7,204,474	0	7,204,474	0	7,204,474	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,768,827	0	1,768,827	0	1,768,827	67.00	
68.00	06800	SPEECH PATHOLOGY	506,520	0	506,520	0	506,520	68.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	24,388		24,388	0	24,388	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,409,164		3,409,164	0	3,409,164	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,499,121		2,499,121	0	2,499,121	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	7,053,751		7,053,751	0	7,053,751	73.00	
74.00	07400	RENAL DIALYSIS	233,593		233,593	0	233,593	74.00	
76.00	03950	DIABETIC EDUCATION	374,819		374,819	0	374,819	76.00	
76.97	07697	CARDIAC REHABILITATION	419,683		419,683	0	419,683	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	204,569		204,569	0	204,569	76.98	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	2,301,302		2,301,302	490	2,301,792	90.00	
91.00	09100	EMERGENCY	8,285,992		8,285,992	0	8,285,992	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,626,910		1,626,910		1,626,910	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	88,838,172	0	88,838,172	34,429	88,872,601	200.00	
201.00		Less Observation Beds	1,626,910		1,626,910		1,626,910	201.00	
202.00		Total (see instructions)	87,211,262	0	87,211,262	34,429	87,245,691	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 9:15 am

			Title XIX			Hospital			
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	16,060,854		16,060,854			30.00	
31.00	03100	INTENSIVE CARE UNIT	5,289,041		5,289,041			31.00	
40.00	04000	SUBPROVIDER - IPF	1,560,351		1,560,351			40.00	
43.00	04300	NURSERY	1,432,898		1,432,898			43.00	
44.00	04400	SKILLED NURSING FACILITY	6,074,805		6,074,805			44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,639,072	37,203,315	46,842,387	0.204876	0.000000	50.00	
51.00	05100	RECOVERY ROOM	909,874	3,279,465	4,189,339	0.179477	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,293,441	390,777	1,684,218	0.239426	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	1,362,150	4,880,822	6,242,972	0.066754	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,271,230	25,964,935	28,236,165	0.160483	0.000000	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	5,922	13,124,120	13,130,042	0.142267	0.000000	55.00	
56.00	05600	RADIOISOTOPE	201,541	4,488,820	4,690,361	0.164610	0.000000	56.00	
57.00	05700	CT SCAN	6,539,671	58,643,040	65,182,711	0.038244	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	789,377	14,763,991	15,553,368	0.083850	0.000000	58.00	
60.00	06000	LABORATORY	13,900,383	30,581,134	44,481,517	0.163112	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	9,756,362	12,536,416	22,292,778	0.117798	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	2,642,482	21,892,550	24,535,032	0.293640	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	2,342,630	4,448,728	6,791,358	0.260453	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	286,543	1,373,136	1,659,679	0.305192	0.000000	68.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	1,498	112,355	113,853	0.214206	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,717,974	3,892,606	6,610,580	0.515713	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,494,288	3,464,251	5,958,539	0.419418	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	12,461,625	18,833,400	31,295,025	0.225395	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	622,689	0	622,689	0.375136	0.000000	74.00	
76.00	03950	DIABETIC EDUCATION	0	33,773	33,773	11.098185	0.000000	76.00	
76.97	07697	CARDIAC REHABILITATION	551	887,401	887,952	0.472642	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	880,069	880,069	0.232447	0.000000	76.98	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	450,457	6,936,218	7,386,675	0.311548	0.000000	90.00	
91.00	09100	EMERGENCY	3,894,380	20,592,145	24,486,525	0.338390	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	272,780	1,676,788	1,949,568	0.834498	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	105,274,869	290,880,255	396,155,124			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	105,274,869	290,880,255	396,155,124			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		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	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03950	DIABETIC EDUCATION	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part I
Date/Time Prepared:
2/28/2020 9:15 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	990,524	0	990,524	9,039	109.58	30.00	
31.00	INTENSIVE CARE UNIT	225,119		225,119	973	231.37	31.00	
40.00	SUBPROVIDER - IPF	159,908	0	159,908	773	206.87	40.00	
43.00	NURSERY	25,292		25,292	744	33.99	43.00	
44.00	SKILLED NURSING FACILITY	249,596		249,596	4,434	56.29	44.00	
200.00	Total (lines 30 through 199)	1,650,439		1,650,439	15,963		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	4,070	445,991					30.00
31.00	INTENSIVE CARE UNIT	570	131,881					31.00
40.00	SUBPROVIDER - IPF	0	0					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	3,128	176,075					44.00
200.00	Total (lines 30 through 199)	7,768	753,947					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/28/2020 9:15 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	1,251,141	46,842,387	0.026710	4,241,169	113,282	50.00
51.00	05100	RECOVERY ROOM	71,266	4,189,339	0.017011	395,110	6,721	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,189	1,684,218	0.020300	4,488	91	52.00
53.00	05300	ANESTHESIOLOGY	63,829	6,242,972	0.010224	581,655	5,947	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	484,218	28,236,165	0.017149	1,626,144	27,887	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	715,801	13,130,042	0.054516	5,922	323	55.00
56.00	05600	RADIOISOTOPE	10,227	4,690,361	0.002180	125,618	274	56.00
57.00	05700	CT SCAN	168,763	65,182,711	0.002589	6,401,270	16,573	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	386,799	15,553,368	0.024869	408,043	10,148	58.00
60.00	06000	LABORATORY	359,642	44,481,517	0.008085	7,391,817	59,763	60.00
65.00	06500	RESPIRATORY THERAPY	267,240	22,292,778	0.011988	5,549,433	66,527	65.00
66.00	06600	PHYSICAL THERAPY	499,606	24,535,032	0.020363	676,089	13,767	66.00
67.00	06700	OCCUPATIONAL THERAPY	74,345	6,791,358	0.010947	644,955	7,060	67.00
68.00	06800	SPEECH PATHOLOGY	12,008	1,659,679	0.007235	146,218	1,058	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,315	113,853	0.029116	1,498	44	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	139,207	6,610,580	0.021058	1,311,968	27,627	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	102,028	5,958,539	0.017123	1,504,188	25,756	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	130,345	31,295,025	0.004165	5,941,206	24,745	73.00
74.00	07400	RENAL DIALYSIS	33,871	622,689	0.054395	479,910	26,105	74.00
76.00	03950	DIABETIC EDUCATION	3,956	33,773	0.117135	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	58,560	887,952	0.065950	334	22	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	10,539	880,069	0.011975	0	0	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	165,797	7,386,675	0.022445	233,504	5,241	90.00
91.00	09100	EMERGENCY	620,241	24,486,525	0.025330	2,235,011	56,613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	133,363	1,949,568	0.068406	130,101	8,900	92.00
200.00		Total (lines 50 through 199)	5,800,296	365,737,175		40,035,651	504,474	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0058		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/28/2020 9:15 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	9,039	0.00	4,070		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	973	0.00	570		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	773	0.00	0		40.00		
43.00	04300	NURSERY	0	0	744	0.00	0		43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	4,434	0.00	3,128		44.00		
200.00		Total (lines 30 through 199)	0	0	15,963		7,768		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: 14-0058		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 9:15 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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description			Title XVIII		Hospital	PPS			
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
			4.00	5.00	6.00	7.00	8.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	46,842,387	0.000000	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	4,189,339	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,684,218	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	6,242,972	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,236,165	0.000000	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	13,130,042	0.000000	55.00	
56.00	05600	RADIOISOTOPE	0	0	0	4,690,361	0.000000	56.00	
57.00	05700	CT SCAN	0	0	0	65,182,711	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	15,553,368	0.000000	58.00	
60.00	06000	LABORATORY	0	0	0	44,481,517	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	22,292,778	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	24,535,032	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,791,358	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,659,679	0.000000	68.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	113,853	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,610,580	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,958,539	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	31,295,025	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	622,689	0.000000	74.00	
76.00	03950	DIABETIC EDUCATION	0	0	0	33,773	0.000000	76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	887,952	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	880,069	0.000000	76.98	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	7,386,675	0.000000	90.00	
91.00	09100	EMERGENCY	0	0	0	24,486,525	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,949,568	0.000000	92.00	
200.00		Total (lines 50 through 199)	0	0	0	365,737,175		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0058		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 9:15 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	4,241,169	0	10,441,277	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	395,110	0	1,005,289	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	4,488	0	7,381	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	581,655	0	1,207,443	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	1,626,144	0	7,172,880	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC		0.000000	5,922	0	5,328,606	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	125,618	0	1,931,886	0	56.00
57.00	05700	CT SCAN		0.000000	6,401,270	0	19,874,746	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	408,043	0	4,380,887	0	58.00
60.00	06000	LABORATORY		0.000000	7,391,817	0	6,966,139	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	5,549,433	0	3,945,867	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	676,089	0	81,683	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	644,955	0	60,794	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	146,218	0	11,064	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	1,498	0	23,969	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	1,311,968	0	947,095	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	1,504,188	0	1,040,109	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	5,941,206	0	5,343,042	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	479,910	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION		0.000000	0	0	5,840	0	76.00
76.97	07697	CARDIAC REHABILITATION		0.000000	334	0	407,658	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	76,133	0	76.98
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	233,504	0	2,183,439	0	90.00
91.00	09100	EMERGENCY		0.000000	2,235,011	0	5,229,988	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	130,101	0	630,111	0	92.00
200.00		Total (lines 50 through 199)			40,035,651	0	78,303,326	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/28/2020 9:15 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	0.204876	10,441,277	0	0	2,139,167	50.00
51.00	05100	RECOVERY ROOM	0.179477	1,005,289	0	0	180,426	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.239426	7,381	0	0	1,767	52.00
53.00	05300	ANESTHESIOLOGY	0.066754	1,207,443	0	0	80,602	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.160483	7,172,880	0	0	1,151,125	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.142267	5,328,606	0	0	758,085	55.00
56.00	05600	RADIOISOTOPE	0.164610	1,931,886	0	0	318,008	56.00
57.00	05700	CT SCAN	0.038244	19,874,746	0	0	760,090	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.083850	4,380,887	0	0	367,337	58.00
60.00	06000	LABORATORY	0.163112	6,966,139	0	0	1,136,261	60.00
65.00	06500	RESPIRATORY THERAPY	0.117798	3,945,867	0	0	464,815	65.00
66.00	06600	PHYSICAL THERAPY	0.293640	81,683	0	0	23,985	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.260453	60,794	0	0	15,834	67.00
68.00	06800	SPEECH PATHOLOGY	0.305192	11,064	0	0	3,377	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.214206	23,969	0	0	5,134	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.515713	947,095	0	0	488,429	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.419418	1,040,109	0	0	436,240	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225395	5,343,042	0	93,018	1,204,295	73.00
74.00	07400	RENAL DIALYSIS	0.375136	0	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	11.098185	5,840	0	0	64,813	76.00
76.97	07697	CARDIAC REHABILITATION	0.472642	407,658	0	0	192,676	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.232447	76,133	0	0	17,697	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.311548	2,183,439	0	0	680,246	90.00
91.00	09100	EMERGENCY	0.338390	5,229,988	0	0	1,769,776	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.834498	630,111	0	0	525,826	92.00
200.00		Subtotal (see instructions)		78,303,326	0	93,018	12,786,011	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		78,303,326	0	93,018	12,786,011	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0058		Period: From 10/01/2018 To 09/30/2019	Worksheet D Part V Date/Time Prepared: 2/28/2020 9:15 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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
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	20,966		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	DIABETIC EDUCATION	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	20,966		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	20,966		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0058

Period:

Worksheet D

Component CCN: 14-S058

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/28/2020 9:15 am

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	1,251,141	46,842,387	0.026710	0	0	50.00
51.00	05100	RECOVERY ROOM	71,266	4,189,339	0.017011	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,189	1,684,218	0.020300	0	0	52.00
53.00	05300	ANESTHESIOLOGY	63,829	6,242,972	0.010224	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	484,218	28,236,165	0.017149	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	715,801	13,130,042	0.054516	0	0	55.00
56.00	05600	RADIOISOTOPE	10,227	4,690,361	0.002180	0	0	56.00
57.00	05700	CT SCAN	168,763	65,182,711	0.002589	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	386,799	15,553,368	0.024869	0	0	58.00
60.00	06000	LABORATORY	359,642	44,481,517	0.008085	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	267,240	22,292,778	0.011988	0	0	65.00
66.00	06600	PHYSICAL THERAPY	499,606	24,535,032	0.020363	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	74,345	6,791,358	0.010947	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,008	1,659,679	0.007235	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,315	113,853	0.029116	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	139,207	6,610,580	0.021058	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	102,028	5,958,539	0.017123	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	130,345	31,295,025	0.004165	0	0	73.00
74.00	07400	RENAL DIALYSIS	33,871	622,689	0.054395	0	0	74.00
76.00	03950	DIABETIC EDUCATION	3,956	33,773	0.117135	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	58,560	887,952	0.065950	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	10,539	880,069	0.011975	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	165,797	7,386,675	0.022445	0	0	90.00
91.00	09100	EMERGENCY	620,241	24,486,525	0.025330	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,949,568	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	5,666,933	365,737,175		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0058 Component CCN: 14-S058		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 9:15 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
55.00	05500	RADIOLOGY - THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION		0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0058 Component CCN: 14-S058		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 9:15 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	46,842,387	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,189,339	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,684,218	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,242,972	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,236,165	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	13,130,042	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	4,690,361	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	65,182,711	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	15,553,368	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	44,481,517	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	22,292,778	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	24,535,032	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,791,358	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,659,679	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	113,853	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,610,580	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,958,539	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	31,295,025	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	622,689	0.000000	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	33,773	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	887,952	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	880,069	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	7,386,675	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,486,525	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,949,568	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	365,737,175		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0058 Component CCN: 14-S058		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 9:15 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	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
55.00	05500	RADIOLOGY - THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
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	03950	DIABETIC EDUCATION		0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0058 Component CCN: 14-5951		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 9:15 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
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
55.00	05500	RADIOLOGY - THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION		0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0058 Component CCN: 14-5951		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 9:15 am	
			Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	46,842,387	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,189,339	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,684,218	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,242,972	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,236,165	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	13,130,042	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	4,690,361	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	65,182,711	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	15,553,368	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	44,481,517	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	22,292,778	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	24,535,032	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,791,358	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,659,679	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	113,853	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,610,580	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,958,539	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	31,295,025	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	622,689	0.000000	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	33,773	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	887,952	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	880,069	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	7,386,675	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,486,525	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,949,568	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	365,737,175		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0058 Component CCN: 14-5951		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 9:15 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000		1,496	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		8,087	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		108,469	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000		0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000		6,920	0	0	0	56.00
57.00	05700	CT SCAN	0.000000		94,844	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		13,775	0	0	0	58.00
60.00	06000	LABORATORY	0.000000		720,158	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		1,399,994	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		1,123,231	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		894,762	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		64,180	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		317,992	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		800,237	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000		0	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	0.000000		0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		217	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000		19,374	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000		0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		0	0	0	0	92.00
200.00		Total (lines 50 through 199)			5,573,736	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0058

Period:

Worksheet D

Component CCN: 14-5951

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/28/2020 9:15 am

Title XVIII

Skilled Nursing
Facility

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	0.204876	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.179477	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.239426	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.066754	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.160483	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.142267	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.164610	0	0	0	56.00
57.00	05700	CT SCAN	0.038244	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.083850	0	0	0	58.00
60.00	06000	LABORATORY	0.163112	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.117798	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.293640	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.260453	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.305192	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.214206	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.515713	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.419418	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225395	0	0	3,677	73.00
74.00	07400	RENAL DIALYSIS	0.375136	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	11.098185	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.472642	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.232447	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.311548	0	0	0	90.00
91.00	09100	EMERGENCY	0.338390	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.834498	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	3,677	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	0	3,677	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part V Date/Time Prepared: 2/28/2020 9:15 am
		Title XVIII	Skilled Nursing Facility	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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
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	829	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	DIABETIC EDUCATION	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	829	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	829	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0058	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/28/2020 9:15 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)			9,039	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			9,039	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			7,822	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			4,070	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)			12,083,486	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)			12,083,486	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)			12,083,486	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)			1,336.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			5,440,857	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			5,440,857	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/28/2020 9:15 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	2,747,822	973	2,824.07	570	1,609,720
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)					7,577,014
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,627,591
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					577,872
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					504,474
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,082,346
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					13,545,245
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)					1,217
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,336.82
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,626,910

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/28/2020 9:15 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	990,524	12,083,486	0.081973	1,626,910	133,363	90.00
91.00 Nursing School cost	0	12,083,486	0.000000	1,626,910	0	91.00
92.00 Allied health cost	0	12,083,486	0.000000	1,626,910	0	92.00
93.00 All other Medical Education	0	12,083,486	0.000000	1,626,910	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0058	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1
		Component CCN: 14-S058		Date/Time Prepared: 2/28/2020 9:15 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)		773	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		773	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)		773	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,759,504	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)		1,759,504	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)		1,759,504	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)		2,276.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0058	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1	
				Component CCN: 14-S058		Date/Time Prepared: 2/28/2020 9:15 am	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0058 Component CCN: 14-S058		Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/28/2020 9:15 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	159,908	1,759,504	0.090882	0	0 90.00
91.00	Nursing School cost	0	1,759,504	0.000000	0	0 91.00
92.00	Allied health cost	0	1,759,504	0.000000	0	0 92.00
93.00	All other Medical Education	0	1,759,504	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/28/2020 9:15 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,434	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,434	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,434	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)		3,128	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)		3,486,768	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)		3,486,768	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)		3,486,768	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0058	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1	
				Component CCN: 14-5951		Date/Time Prepared: 2/28/2020 9:15 am	
				Title XVIII		Skilled Nursing Facility	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					3,486,768	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					786.37	71.00
72.00	Program routine service cost (line 9 x line 71)					2,459,765	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					2,459,765	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					2,459,765	83.00
84.00	Program inpatient ancillary services (see instructions)					1,239,619	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					3,699,384	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: 14-0058

Period:

Worksheet D-1

Component CCN: 14-5951

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:15 am

Title XVIII

Skilled Nursing
Facility

PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0058	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/28/2020 9:15 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		7,313,124	30.00
31.00	03100	INTENSIVE CARE UNIT		3,186,404	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.204876	4,241,169	50.00
51.00	05100	RECOVERY ROOM	0.179477	395,110	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.239426	4,488	52.00
53.00	05300	ANESTHESIOLOGY	0.066754	581,655	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.160541	1,626,144	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.142267	5,922	55.00
56.00	05600	RADIOISOTOPE	0.164610	125,618	56.00
57.00	05700	CT SCAN	0.038244	6,401,270	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.083850	408,043	58.00
60.00	06000	LABORATORY	0.163112	7,391,817	60.00
65.00	06500	RESPIRATORY THERAPY	0.117868	5,549,433	65.00
66.00	06600	PHYSICAL THERAPY	0.293640	676,089	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.260453	644,955	67.00
68.00	06800	SPEECH PATHOLOGY	0.305192	146,218	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.214206	1,498	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.515713	1,311,968	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.419418	1,504,188	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225395	5,941,206	73.00
74.00	07400	RENAL DIALYSIS	0.375136	479,910	74.00
76.00	03950	DIABETIC EDUCATION	11.098185	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.472642	334	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.232447	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.311614	233,504	90.00
91.00	09100	EMERGENCY	0.338390	2,235,011	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.834498	130,101	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		40,035,651	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)		40,035,651	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0058 Component CCN: 14-S058	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/28/2020 9:15 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		0		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.204876	0	0	50.00
51.00	05100 RECOVERY ROOM	0.179477	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.239426	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.066754	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.160541	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.142267	0	0	55.00
56.00	05600 RADIOISOTOPE	0.164610	0	0	56.00
57.00	05700 CT SCAN	0.038244	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.083850	0	0	58.00
60.00	06000 LABORATORY	0.163112	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.117868	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.293640	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.260453	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.305192	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.214206	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.515713	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.419418	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.225395	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.375136	0	0	74.00
76.00	03950 DIABETIC EDUCATION	11.098185	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.472642	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.232447	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.311614	0	0	90.00
91.00	09100 EMERGENCY	0.338390	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.834498	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/28/2020 9:15 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.204876	1,496	306	50.00
51.00	05100 RECOVERY ROOM	0.179477	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.239426	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.066754	8,087	540	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.160541	108,469	17,414	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.142267	0	0	55.00
56.00	05600 RADIOISOTOPE	0.164610	6,920	1,139	56.00
57.00	05700 CT SCAN	0.038244	94,844	3,627	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.083850	13,775	1,155	58.00
60.00	06000 LABORATORY	0.163112	720,158	117,466	60.00
65.00	06500 RESPIRATORY THERAPY	0.117868	1,399,994	165,014	65.00
66.00	06600 PHYSICAL THERAPY	0.293640	1,123,231	329,826	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.260453	894,762	233,043	67.00
68.00	06800 SPEECH PATHOLOGY	0.305192	64,180	19,587	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.214206	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.515713	317,992	163,993	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.419418	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.225395	800,237	180,369	73.00
74.00	07400 RENAL DIALYSIS	0.375136	0	0	74.00
76.00	03950 DIABETIC EDUCATION	11.098185	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.472642	217	103	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.232447	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.311614	19,374	6,037	90.00
91.00	09100 EMERGENCY	0.338390	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.834498	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,573,736	1,239,619	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		5,573,736		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A
Date/Time Prepared:
2/28/2020 9:15 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)			0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			9,274,567	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)				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
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			351,530	2.04
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)			98.67	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)			5.20	30.00
31.00	Percentage of Medicaid patient days (see instructions)			18.10	31.00
32.00	Sum of lines 30 and 31			23.30	32.00
33.00	Allowable disproportionate share percentage (see instructions)			8.44	33.00
34.00	Disproportionate share adjustment (see instructions)			195,693	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0058	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/28/2020 9:15 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	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000062804		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	505,528	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	505,528	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		505,528		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)		10,327,318		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		12,199,893		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			12,199,893	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			774,129	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)			12,974,022	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			12,974,022	61.00
62.00	Deductibles billed to program beneficiaries			1,193,604	62.00
63.00	Coinsurance billed to program beneficiaries			5,432	63.00
64.00	Allowable bad debts (see instructions)			476,669	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			309,835	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			459,858	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			12,084,821	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			70,389	70.93
70.94	HRR adjustment amount (see instructions)			0	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A
Date/Time Prepared:
2/28/2020 9:15 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	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	18,040	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		12,173,250	71.00	
71.01	Sequestration adjustment (see instructions)		243,465	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		11,930,806	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)		-1,021	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0058	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/28/2020 9:15 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		20,966	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		12,786,011	2.00
3.00	OPPS payments		11,373,622	3.00
4.00	Outlier payment (see instructions)		11,190	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)		20,966	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		93,018	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)		93,018	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)		93,018	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		72,052	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)		20,966	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)		11,384,812	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,283,883	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)		9,121,895	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)		9,121,895	30.00
31.00	Primary payer payments		4,058	31.00
32.00	Subtotal (line 30 minus line 31)		9,117,837	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)		625,021	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		406,264	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		607,236	36.00
37.00	Subtotal (see instructions)		9,524,101	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-32	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)		9,524,133	40.00
40.01	Sequestration adjustment (see instructions)		190,483	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		9,284,661	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		48,989	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: 14-0058 Component CCN: 14-5951	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/28/2020 9:15 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		829	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		829	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		3,677	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		3,677	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)		3,677	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,848	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)		829	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			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)		829	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)		829	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		829	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)		829	37.00
38.00	MSP-LCC reconciliation amount from PS&R			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)		829	40.00
40.01	Sequestration adjustment (see instructions)		17	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		829	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-17	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)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/28/2020 9:15 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		12,109,230		9,271,014	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	05/13/2019	13,647	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	05/13/2019	178,424		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)		-178,424		13,647	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)		11,930,806		9,284,661	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		48,989	6.01
6.02	SETTLEMENT TO PROGRAM		1,021		0	6.02
7.00	Total Medicare program liability (see instructions)		11,929,785		9,333,650	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: 14-0058
 Component CCN: 14-S058

 Period:
 From 10/01/2018
 To 09/30/2019

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/28/2020 9:15 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		0		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		0		0	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: 14-0058 Component CCN: 14-5951		Period: From 10/01/2018 To 09/30/2019		Worksheet E-1 Part I Date/Time Prepared: 2/28/2020 9:15 am	
		Title XVIII		Skilled Nursing Facility		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider						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		1,052,778		829		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,052,778		829		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		17		6.02
7.00	Total Medicare program liability (see instructions)		1,052,778		812		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0058	Period: From 10/01/2018 To 09/30/2019	Worksheet E-1 Part II Date/Time Prepared: 2/28/2020 9:15 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: 14-0058 Component CCN: 14-S058	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part II Date/Time Prepared: 2/28/2020 9:15 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)		0	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		2.117808	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)		0	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		0	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		0	18.00
19.00	Deductibles		0	19.00
20.00	Subtotal (line 18 minus line 19)		0	20.00
21.00	Coinurance		0	21.00
22.00	Subtotal (line 20 minus line 21)		0	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		0	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (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)		0	31.00
31.01	Sequestration adjustment (see instructions)		0	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		0	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part VI Date/Time Prepared: 2/28/2020 9:15 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			1,239,367 1.00
2.00	Routine service other pass through costs			0 2.00
3.00	Ancillary service other pass through costs			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			1,239,367 4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0 6.00
7.00	Coinsurance			165,104 7.00
8.00	Allowable bad debts (see instructions)			0 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			0 10.00
11.00	Utilization review			0 11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			1,074,263 12.00
13.00	Inpatient primary payer payments			0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 14.50
14.99	Demonstration payment adjustment amount before sequestration			0 14.99
15.00	Subtotal (see instructions)			1,074,263 15.00
15.01	Sequestration adjustment (see instructions)			21,485 15.01
15.02	Demonstration payment adjustment amount after sequestration			0 15.02
16.00	Interim payments			1,052,778 16.00
17.00	Tentative settlement (for contractor use only)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)			0 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0 19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0058	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 2/28/2020 9:15 am	
		Title XIX	Hospital	Inpatient	Outpatient
				1.00	2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0058 Component CCN: 14-S058	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 2/28/2020 9:15 am	
		Title XIX	Subprovider - IPF		
			Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet G

Date/Time Prepared:
2/28/2020 9:15 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	2,905,978	0	0	0	1.00
2.00	Temporary investments	2,771,262	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	23,307,940	0	0	0	4.00
5.00	Other receivable	337,476	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,386,895	0	0	0	6.00
7.00	Inventory	1,645,492	0	0	0	7.00
8.00	Prepaid expenses	958,074	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	29,539,327	0	0	0	11.00
FIXED ASSETS						
12.00	Land	735,200	0	0	0	12.00
13.00	Land improvements	1,281,184	0	0	0	13.00
14.00	Accumulated depreciation	-337,394	0	0	0	14.00
15.00	Buildings	11,135,433	0	0	0	15.00
16.00	Accumulated depreciation	-2,087,212	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	20,966,119	0	0	0	19.00
20.00	Accumulated depreciation	-5,644,718	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	20,628,576	0	0	0	23.00
24.00	Accumulated depreciation	-11,080,376	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	702,567	0	0	0	27.00
28.00	Accumulated depreciation	-702,422	0	0	0	28.00
29.00	Minor equipment-nondepreciable	3,076,060	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	38,673,017	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	84,419,622	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	25,261,638	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	109,681,260	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	177,893,604	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,038,449	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,604,840	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,327,000	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	6,136,352	0	0	0	43.00
44.00	Other current liabilities	3,011,372	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,118,013	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	17,549,458	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	7,716,341	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	25,265,799	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	42,383,812	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	135,509,792	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	135,509,792	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	177,893,604	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-1

Date/Time Prepared:
2/28/2020 9:15 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		133,300,399		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,135,000				2.00
3.00	Total (sum of line 1 and line 2)		139,435,399		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		139,435,399		0		11.00
12.00	TRANSFERS TO RELATED ORGANIZATIONS	3,272,407		0		0	12.00
13.00	PENSION AND OTHER ADJUSTMENTS	653,200		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)		3,925,607		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		135,509,792		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	TRANSFERS TO RELATED ORGANIZATIONS		0				12.00
13.00	PENSION AND OTHER ADJUSTMENTS		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: 14-0058

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/28/2020 9:15 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	17,493,752		17,493,752	1.00
2.00	SUBPROVIDER - IPF	1,560,351		1,560,351	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	6,074,805		6,074,805	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)	25,128,908		25,128,908	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,289,041		5,289,041	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)	5,289,041		5,289,041	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	30,417,949		30,417,949	17.00
18.00	Ancillary services	70,239,304	261,675,105	331,914,409	18.00
19.00	Outpatient services	4,617,616	29,205,151	33,822,767	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	1,036,706	7,786,251	8,822,957	27.00
27.01	PHYSICIAN REVENUE - NRCC	0	1,685	1,685	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	106,311,575	298,668,192	404,979,767	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		101,957,867		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)		101,957,867		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0058

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-3

Date/Time Prepared:
2/28/2020 9:15 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	404,979,767	1.00
2.00	Less contractual allowances and discounts on patients' accounts	299,910,600	2.00
3.00	Net patient revenues (line 1 minus line 2)	105,069,167	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	101,957,867	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,111,300	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	306,348	6.00
7.00	Income from investments	1,313,929	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	563,968	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	28,149	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	16,745	21.00
22.00	Rental of hospital space	474,272	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	306,511	24.00
24.01	LIFELINE	104,353	24.01
25.00	Total other income (sum of lines 6-24)	3,114,275	25.00
26.00	Total (line 5 plus line 25)	6,225,575	26.00
27.00	RETIREE BENEFIT ADJUSTMENT	90,575	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	90,575	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,135,000	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0058	Period: From 10/01/2018 To 09/30/2019	Worksheet L Parts I-III Date/Time Prepared: 2/28/2020 9:15 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		749,359	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		24,770	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)		24.53	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)		774,129	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