

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: 14-0100	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/27/2019 10:56 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically filed cost report 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 MIDWESTERN REGIONAL MEDICAL CENTER (14-0100) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 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) R. LEE PIEKARZ
 Officer or Administrator of Provider(s)

VIP OF FINANCE
 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	11,577	281,090	0	0	1.00
2.00	Subprovider - IPF	0	0	0	0	0	2.00
3.00	Subprovider - IRF	0	0	0	0	0	3.00
5.00	Swing bed - SNF	0	0	0	0	0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	11,577	281,090	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: 14-0100		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/27/2019 10:56 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 2501 EMMAUS AVENUE			PO Box:				1.00			
2.00	City: ZION			State: IL		Zip Code: 60099		County: LAKE			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		MIDWESTERN REGIONAL MEDICAL CENTER		140100	29404	1	07/01/1967	N	P	O
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2018	06/30/2019		20.00	
21.00	Type of Control (see instructions)						4			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0	N			23.00	
					In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
					1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.					0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	Y	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.							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: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0
						71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N
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
						75.00
						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	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N			110.00

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			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,088,340	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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		14H130	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0100		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/27/2019 10:56 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: CTCA	Contractor's Name: FCSO			Contractor's Number: 09001			141.00	
142.00	Street: 5900 BROKEN SOUND PARKWAY NW	PO Box:						142.00	
143.00	City: BOCA RATON	State: FL			Zip Code: 33487			143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							N	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.99	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					07/01/2018	06/30/2019		170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0100	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/27/2019 10:56 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	10/31/2019
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		N
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)	Y	10/09/2019	Y
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: 14-0100	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/27/2019 10:56 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		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.	STEPHANIE	GALE	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.	612-376-4500	STEPHANIE.GALE@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/27/2019 10:56 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PRINCIPAL	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: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/27/2019 10:56 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	49	17,885	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)		49	17,885	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	24	8,760	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	34.00	0	0	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		73	26,645	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						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)		73			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: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/27/2019 10:56 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	791	0	3,836			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	791	0	3,836			7.00
8.00	INTENSIVE CARE UNIT	1,089	2	4,283			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,880	2	8,119	0.00	828.50	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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	828.50	27.00
28.00	Observation Bed Days		5	986			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/27/2019 10:56 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	331	1	1,395	1.00
2.00 HMO and other (see instructions)			0	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	331	1	1,395	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						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: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/27/2019 10:56 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	54,700,802	0	54,700,802	1,723,274.40	31.74
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		3,741,772	-72,011	3,669,761	172,119.68	21.32
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		136,213	0	136,213	2,103.50	64.76
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		19,591,227	0	19,591,227	388,751.74	50.40
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		16,868,842	0	16,868,842		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,871,805	0	1,871,805		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		10,915,510	0	10,915,510		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	757,697	-80,053	677,644	15,115.69	44.83
27.00	Administrative & General	5.00	7,286,105	92,657	7,378,762	187,417.39	39.37

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/27/2019 10:56 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		405,310	0	405,310	1,091.41	371.36	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,344,900	1,864	1,346,764	57,653.91	23.36	30.00
31.00	Laundry & Linen Service	8.00	42,236	0	42,236	2,361.75	17.88	31.00
32.00	Housekeeping	9.00	1,445,581	2,003	1,447,584	99,202.63	14.59	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,299,624	-1,234,652	64,972	4,003.51	16.23	34.00
35.00	Dietary under contract (see instructions)		73,411	0	73,411	3,735.00	19.65	35.00
36.00	Cafeteria	11.00	65,600	1,236,544	1,302,144	81,475.48	15.98	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,150,300	1,594	1,151,894	26,905.30	42.81	38.00
39.00	Central Services and Supply	14.00	26	0	26	0.00	0.00	39.00
40.00	Pharmacy	15.00	2,651,849	3,675	2,655,524	69,181.61	38.38	40.00
41.00	Medical Records & Medical Records Library	16.00	954,426	1,322	955,748	36,730.57	26.02	41.00
42.00	Social Service	17.00	267,943	371	268,314	8,572.40	31.30	42.00
43.00	Other General Service	18.00	1,473,977	2,042	1,476,019	38,037.57	38.80	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part III
Date/Time Prepared:
11/27/2019 10:56 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	55,179,523	0	55,179,523	1,728,100.81	31.93	1.00
2.00	Excluded area salaries (see instructions)	3,741,772	-72,011	3,669,761	172,119.68	21.32	2.00
3.00	Subtotal salaries (line 1 minus line 2)	51,437,751	72,011	51,509,762	1,555,981.13	33.10	3.00
4.00	Subtotal other wages & related costs (see inst.)	19,727,440	0	19,727,440	390,855.24	50.47	4.00
5.00	Subtotal wage-related costs (see inst.)	27,784,352	0	27,784,352	0.00	53.94	5.00
6.00	Total (sum of lines 3 thru 5)	98,949,543	72,011	99,021,554	1,946,836.37	50.86	6.00
7.00	Total overhead cost (see instructions)	19,218,985	27,367	19,246,352	631,484.22	30.48	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part IV
Date/Time Prepared:
11/27/2019 10:56 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,500,246	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)	8,485,497	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	2,117,847	9.00
10.00	Dental, Hearing and Vision Plan	827,231	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	22,980	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	423,228	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	733,952	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	15,400	14.00
15.00	'Workers' Compensation Insurance	332,972	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	3,822,593	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	457,870	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	832	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	18,740,648	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part V
Date/Time Prepared:
11/27/2019 10:56 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	136,213	18,740,648	1.00
2.00	Hospital	136,213	18,740,648	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0100	Period: From 07/01/2018 To 06/30/2019	Worksheet S-10 Date/Time Prepared: 11/27/2019 10:56 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.219326 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	1,721,328		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	3,160,682		6.00
7.00	Medicaid cost (line 1 times line 6)	693,220		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	99,122	56,919,909	57,019,031 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	21,740	56,919,909	56,941,649 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	21,740	56,919,909	56,941,649 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)	5,767,698		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	452,495		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	696,146		27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,071,552		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,355,974		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	58,297,623		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	58,297,623		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019

Worksheet A

Date/Time Prepared:
11/27/2019 10:56 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		20,037,026	20,037,026	-126,843	19,910,183	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		8,953,064	8,953,064	0	8,953,064	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	757,697	12,756,938	13,514,635	282,174	13,796,809	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,286,105	150,337,758	157,623,863	-598,395	157,025,468	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,344,900	4,227,144	5,572,044	1,864	5,573,908	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	42,236	362,629	404,865	0	404,865	8.00
9.00	00900	HOUSEKEEPING	1,445,581	592,397	2,037,978	2,003	2,039,981	9.00
10.00	01000	DIETARY	1,299,624	2,084,006	3,383,630	-3,214,617	169,013	10.00
11.00	01100	CAFETERIA	65,600	64,090	129,690	3,216,509	3,346,199	11.00
13.00	01300	NURSING ADMINISTRATION	1,150,300	294,767	1,445,067	1,594	1,446,661	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26	837,512	837,538	0	837,538	14.00
15.00	01500	PHARMACY	2,651,849	1,166,703	3,818,552	3,675	3,822,227	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	954,426	135,538	1,089,964	1,322	1,091,286	16.00
17.00	01700	SOCIAL SERVICE	267,943	47,117	315,060	371	315,431	17.00
18.00	01850	OTHER GENERAL SERVICES	1,473,977	274,012	1,747,989	2,042	1,750,031	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,525,435	769,698	4,295,133	4,885	4,300,018	30.00
31.00	03100	INTENSIVE CARE UNIT	2,905,076	618,039	3,523,115	4,025	3,527,140	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,275,517	8,168,927	12,444,444	5,924	12,450,368	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,587,647	3,267,169	5,854,816	3,586	5,858,402	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,702,683	3,435,238	5,137,921	2,359	5,140,280	55.00
56.00	05600	RADIOISOTOPE	384,875	2,999,446	3,384,321	533	3,384,854	56.00
57.00	05700	CT SCAN	528,216	789,506	1,317,722	732	1,318,454	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	459,491	536,391	995,882	637	996,519	58.00
60.00	06000	LABORATORY	2,168,531	4,216,664	6,385,195	3,005	6,388,200	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,654,075	1,654,075	0	1,654,075	63.00
64.00	06400	INTRAVENOUS THERAPY	1,530,007	420,530	1,950,537	2,120	1,952,657	64.00
65.00	06500	RESPIRATORY THERAPY	961,447	396,490	1,357,937	1,332	1,359,269	65.00
66.00	06600	PHYSICAL THERAPY	1,256,238	259,815	1,516,053	1,741	1,517,794	66.00
69.00	06900	ELECTROCARDIOLOGY	377,542	117,162	494,704	523	495,227	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	83,705,712	83,705,712	0	83,705,712	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	436,311	92,717	529,028	605	529,633	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,367,241	1,266,116	9,633,357	11,594	9,644,951	90.00
91.00	09100	EMERGENCY	752,509	226,730	979,239	1,043	980,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	291,857	291,857	-337,569	-45,712	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,959,030	315,402,983	366,362,013	-721,226	365,640,787	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190	190	0	190	190.00
191.00	19100	RESEARCH	0	34	34	0	34	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	3,741,772	25,294,044	29,035,816	721,226	29,757,042	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	54,700,802	340,697,251	395,398,053	0	395,398,053	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019

Worksheet A

Date/Time Prepared:
11/27/2019 10:56 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-3,312,848	16,597,335	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,925,638	12,878,702	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-29,255	13,767,554	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-93,688,994	63,336,474	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	5,573,908	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	404,865	8.00
9.00	00900	HOUSEKEEPING	0	2,039,981	9.00
10.00	01000	DIETARY	164	169,177	10.00
11.00	01100	CAFETERIA	-617,513	2,728,686	11.00
13.00	01300	NURSING ADMINISTRATION	-69	1,446,592	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	837,538	14.00
15.00	01500	PHARMACY	20	3,822,247	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,808	1,077,478	16.00
17.00	01700	SOCIAL SERVICE	0	315,431	17.00
18.00	01850	OTHER GENERAL SERVICES	-24,604	1,725,427	18.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	4,300,018	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,527,140	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-20	12,450,348	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,858,402	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,140,280	55.00
56.00	05600	RADIOISOTOPE	0	3,384,854	56.00
57.00	05700	CT SCAN	0	1,318,454	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	996,519	58.00
60.00	06000	LABORATORY	0	6,388,200	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,654,075	63.00
64.00	06400	INTRAVENOUS THERAPY	-13,025	1,939,632	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,359,269	65.00
66.00	06600	PHYSICAL THERAPY	-48,855	1,468,939	66.00
69.00	06900	ELECTROCARDIOLOGY	0	495,227	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	83,705,712	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	529,633	76.01
76.02	03952	PAIN MANAGEMENT	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	9,644,951	90.00
91.00	09100	EMERGENCY	0	980,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	45,712	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-93,777,457	271,863,330	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190	190.00
191.00	19100	RESEARCH	0	34	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	29,757,042	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-93,777,457	301,620,596	200.00

RECLASSIFICATIONS

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS CAFETERIA					
1.00	CAFETERIA	11.00	1,236,453	1,979,965		1.00
	0		1,236,453	1,979,965		
	B - EMPLOYEE BONUS					
1.00	ADMINISTRATIVE & GENERAL	5.00	15,461	0		1.00
2.00	OPERATION OF PLANT	7.00	1,864	0		2.00
3.00	HOUSEKEEPING	9.00	2,003	0		3.00
4.00	DIETARY	10.00	1,801	0		4.00
5.00	CAFETERIA	11.00	91	0		5.00
6.00	NURSING ADMINISTRATION	13.00	1,594	0		6.00
8.00	PHARMACY	15.00	3,675	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	1,322	0		9.00
10.00	SOCIAL SERVICE	17.00	371	0		10.00
11.00	OTHER GENERAL SERVICES	18.00	2,042	0		11.00
12.00	ADULTS & PEDIATRICS	30.00	4,885	0		12.00
13.00	INTENSIVE CARE UNIT	31.00	4,025	0		13.00
15.00	OPERATING ROOM	50.00	5,924	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	3,586	0		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	2,359	0		17.00
18.00	RADIOISOTOPE	56.00	533	0		18.00
19.00	CT SCAN	57.00	732	0		19.00
20.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	637	0		20.00
21.00	LABORATORY	60.00	3,005	0		21.00
23.00	INTRAVENOUS THERAPY	64.00	2,120	0		23.00
24.00	RESPIRATORY THERAPY	65.00	1,332	0		24.00
25.00	PHYSICAL THERAPY	66.00	1,741	0		25.00
26.00	ELECTROCARDIOLOGY	69.00	523	0		26.00
27.00	HOSPITAL NUTRITION	76.01	605	0		27.00
29.00	CLINIC	90.00	11,594	0		29.00
30.00	EMERGENCY	91.00	1,043	0		30.00
33.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	5,185	0		33.00
	0		80,053	0		
	C - PROPERTY TAX					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	851,450		1.00
	0		0	851,450		
	D - TRAVEL/SCHEDULING					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	23,875	4,770		1.00
	0		23,875	4,770		
	E - GUEST SERVICES					
1.00		0.00	0	0		1.00
	0		0	0		
	F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	337,569		1.00
	0		0	337,569		
	G - INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	396,667		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	362,227		2.00
	0		0	758,894		
	H - TRANSPORTATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	101,071	72,612		1.00
	0		101,071	72,612		
	I - GUEST ACCOMODATIONS DEPRECIATION					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	9,629		1.00
	TOTALS		0	9,629		
500.00	Grand Total: Increases		1,441,452	4,014,889		500.00

RECLASSIFICATIONS

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-6

Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA						
1.00	DIETARY	10.00	1,236,453	1,979,965	0		1.00
	0		1,236,453	1,979,965			
	B - EMPLOYEE BONUS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	80,053	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
33.00		0.00	0	0	0		33.00
	0		80,053	0			
	C - PROPERTY TAX						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	851,450	13		1.00
	0		0	851,450			
	D - TRAVEL/SCHEDULING						
1.00	ADMINISTRATIVE & GENERAL	5.00	23,875	4,770	0		1.00
	0		23,875	4,770			
	E - GUEST SERVICES						
1.00		0.00	0	0	0		1.00
	0		0	0			
	F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	337,569	11		1.00
	0		0	337,569			
	G - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	758,894	12		1.00
2.00		0.00	0	0	0		2.00
	0		0	758,894			
	H - TRANSPORTATION						
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	101,071	72,612	0		1.00
	0		101,071	72,612			
	I - GUEST ACCOMODATIONS DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,629	9		1.00
	TOTALS		0	9,629			
500.00	Grand Total: Decreases		1,441,452	4,014,889			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00	
2.00	Land Improvements	1,126,605	0	0	0	0	2.00	
3.00	Buildings and Fixtures	36,367,369	1,066,689	0	1,066,689	3,312,915	3.00	
4.00	Building Improvements	168,098,973	3,210,619	0	3,210,619	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	98,034,131	1,184,462	0	1,184,462	3,521,422	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	303,627,078	5,461,770	0	5,461,770	6,834,337	8.00	
9.00	Reconciling Items	14,328,296	1,066,689	0	1,066,689	3,312,915	9.00	
10.00	Total (line 8 minus line 9)	289,298,782	4,395,081	0	4,395,081	3,521,422	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0					1.00
2.00	Land Improvements	1,126,605	0					2.00
3.00	Buildings and Fixtures	34,121,143	0					3.00
4.00	Building Improvements	171,309,592	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	95,697,171	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	302,254,511	0					8.00
9.00	Reconciling Items	12,082,070	0					9.00
10.00	Total (line 8 minus line 9)	290,172,441	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	10,703,263	0	0	0	4,590,097	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,662,538	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	16,365,801	0	0	0	4,590,097	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	4,743,666	20,037,026				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,290,526	8,953,064				2.00
3.00	Total (sum of lines 1-2)	8,034,192	28,990,090				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	206,557,339	30,640,020	175,917,319	0.790719	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	95,697,171	49,136,793	46,560,378	0.209281	0	2.00
3.00	Total (sum of lines 1-2)	302,254,510	79,776,813	222,477,697	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	11,849,858	-4,448,029	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	10,593,787	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	22,443,645	-4,448,029	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	337,569	375,624	3,738,647	4,743,666	16,597,335	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,284,915	12,878,702	2.00
3.00	Total (sum of lines 1-2)	337,569	375,624	3,738,647	7,028,581	29,476,037	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8

Date/Time Prepared:
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Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			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	-77,875,201			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-617,513	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-34,312	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	998,954	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0	0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0100

Period:
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To 06/30/2019

Worksheet A-8

Date/Time Prepared:
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Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER REVENUE		0		0.00	0	33.00
33.01	OTHER REVENUE	B	-302,519	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER REVENUE	B	39	PHARMACY	15.00	0	33.02
33.03	OTHER REVENUE		0		0.00	0	33.03
33.04	OTHER REVENUE	B	-13,808	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05	OTHER REVENUE	B	-8,295	OTHER GENERAL SERVICES	18.00	0	33.05
33.06	OTHER REVENUE	B	-13,025	INTRAVENOUS THERAPY	64.00	0	33.06
33.07	OTHER REVENUE		0		0.00	0	33.07
33.08	OTHER REVENUE		0		0.00	0	33.08
33.09	OTHER REVENUE		0		0.00	0	33.09
33.10	OTHER REVENUE		0		0.00	0	33.10
33.11	OTHER REVENUE	B	-48,855	PHYSICAL THERAPY	66.00	0	33.11
34.00	NON-ALLOWABLE EXPENSE		0		0.00	0	34.00
34.01	NON-ALLOWABLE EXPENSE		0		0.00	0	34.01
34.02	NON-ALLOWABLE EXPENSE		0		0.00	0	34.02
34.03	NON-ALLOWABLE EXPENSE	A	-20	OPERATING ROOM	50.00	0	34.03
34.04	NON-ALLOWABLE EXPENSE		0		0.00	0	34.04
34.05	NON-ALLOWABLE EXPENSE		0		0.00	0	34.05
34.06	NON-ALLOWABLE EXPENSE		0		0.00	0	34.06
34.07	NON-ALLOWABLE EXPENSE		0		0.00	0	34.07
34.08	NON-ALLOWABLE EXPENSE	A	-16,309	OTHER GENERAL SERVICES	18.00	0	34.08
34.09	NON-ALLOWABLE EXPENSE	A	164	DIETARY	10.00	0	34.09
34.10	NON-ALLOWABLE EXPENSE		0		0.00	0	34.10
34.11	NON-ALLOWABLE EXPENSE	A	-15,782,620	ADMINISTRATIVE & GENERAL	5.00	0	34.11
34.12	NON-ALLOWABLE EXPENSE		0		0.00	0	34.12
34.13	NON-ALLOWABLE EXPENSE		0		0.00	0	34.13
34.14	NON-ALLOWABLE EXPENSE		0		0.00	0	34.14
34.15	NON-ALLOWABLE EXPENSE		0		0.00	0	34.15
34.16	NON-ALLOWABLE EXPENSE		0		0.00	0	34.16
34.17	NON-ALLOWABLE EXPENSE		0		0.00	0	34.17
34.18	NON-ALLOWABLE EXPENSE		0		0.00	0	34.18
34.19	NON-ALLOWABLE EXPENSE		0		0.00	0	34.19
34.20	NON-ALLOWABLE EXPENSE	A	-69	NURSING ADMINISTRATION	13.00	0	34.20
34.21	NON-ALLOWABLE EXPENSE		0		0.00	0	34.21
34.22	NON-ALLOWABLE EXPENSE		0		0.00	0	34.22
34.23	NON-ALLOWABLE EXPENSE		0		0.00	0	34.23
34.24	NON-ALLOWABLE EXPENSE		0		0.00	0	34.24
34.25	NON-ALLOWABLE EXPENSE	A	-19	PHARMACY	15.00	0	34.25
34.26	NON-ALLOWABLE EXPENSE		0		0.00	0	34.26
34.27	NON-ALLOWABLE EXPENSE		0		0.00	0	34.27
35.00	CAFETERIA		0		0.00	0	35.00
36.00	CONSULTING FEES		0		0.00	0	36.00
37.00	EMR AMORTIZATION	A	-64,049	ADMINISTRATIVE & GENERAL	5.00	0	37.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-93,777,457				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: 14-0100

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-1

Date/Time Prepared:

11/27/2019 10:56 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	0.00		MANAGEMENT FEES	0	0	1.00
2.00	0.00		RISING TIDE IP REIMBURSEMENT	0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	TRAVEL - AIR CHARTER	114,561	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	GUARANTEE FEES	0	21,722	4.00
4.01	113.00	INTEREST EXPENSE	INTEREST EXPENSE - OTHER	0	95,625	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES	3,242,170	3,242,170	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES -	0	1,005,611	4.03
4.04	113.00	INTEREST EXPENSE	INTEREST EXPENSE - GCF	0	196,232	4.04
4.05	113.00	INTEREST EXPENSE	INTEREST EXPENSE - CAPITAL L	337,569	0	4.05
4.06	1.00	CAP REL COSTS-BLDG & FIXT	RENTAL - BLDG	258,625	4,706,654	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES - NEW	0	45,959,624	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY EXPENSE	0	83,282,673	4.08
4.09	1.00	CAP REL COSTS-BLDG & FIXT	INSURANCE	375,624	396,667	4.09
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	INSURANCE	332,972	362,227	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	INSURANCE	1,365,231	1,252,143	4.11
4.12	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	1,190,536	0	4.12
4.13	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	3,932,295	0	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	51,496,564	0	4.14
4.15	0.00			0	0	4.15
5.00	0			62,646,147	140,521,348	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	A	MIDWESTERN REG	100.00	NIMP	100.00	6.00
7.00	A	MIDWESTERN REG	100.00	CTCA	100.00	7.00
8.00	A	MIDWESTERN REG	100.00	ICIC	100.00	8.00
9.00	A	MIDWESTERN REG	100.00	INTERNATIONAL A	100.00	9.00
10.00	A	MIDWESTERN REG	100.00	SCL	100.00	10.00
10.01	A	MIDWESTERN REG	100.00	EXPEDITION PROP	100.00	10.01
10.02	A	MIDWESTERN REG	100.00	BUCKLEY RD PR	100.00	10.02
10.03	A	MIDWESTERN REG	100.00	LAND TRUST	100.00	10.03
10.04	A	MIDWESTERN REG	100.00	GCF	100.00	10.04
10.05	A	MIDWESTERN REG	100.00	STELLAR INS	100.00	10.05
10.06	A	MIDWESTERN REG	100.00	ICMC	100.00	10.06
10.07			0.00		0.00	10.07
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: 14-0100

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-1

Date/Time Prepared:
11/27/2019 10:56 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	0		1.00
2.00	0	0		2.00
3.00	114,561	0		3.00
4.00	-21,722	0		4.00
4.01	-95,625	0		4.01
4.02	0	14		4.02
4.03	-1,005,611	14		4.03
4.04	-196,232	0		4.04
4.05	337,569	0		4.05
4.06	-4,448,029	10		4.06
4.07	-45,959,624	0		4.07
4.08	-83,282,673	0		4.08
4.09	-21,043	12		4.09
4.10	-29,255	0		4.10
4.11	113,088	0		4.11
4.12	1,190,536	9		4.12
4.13	3,932,295	9		4.13
4.14	51,496,564	0		4.14
4.15	0	0		4.15
5.00	-77,875,201			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	PROPERTY		6.00
7.00	MANAGEMENT		7.00
8.00	CONSULTING		8.00
9.00	CORPORATE JET		9.00
10.00	SECURITIES FINA		10.00
10.01	RENTS BLDG SHAR		10.01
10.02	PROPERTY COMP		10.02
10.03	PROPERTY COMP		10.03
10.04	FINANCIAL		10.04
10.05	INSURANCE		10.05
10.06	CAPITAL MANAGEM		10.06
10.07			10.07
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: 14-0100

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-2

Date/Time Prepared:
11/27/2019 10:56 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	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	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	0.00		0	0	0	0		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/27/2019 10:56 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	16,597,335	16,597,335			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	12,878,702		12,878,702		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,767,554	91,624	2,433	13,861,611	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	63,336,474	844,069	3,955,103	1,893,287	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	5,573,908	2,429,259	406,808	345,561	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	404,865	0	0	10,837	8.00
9.00	00900	HOUSEKEEPING	2,039,981	227,733	27,910	371,430	9.00
10.00	01000	DIETARY	169,177	39,498	175,819	16,671	10.00
11.00	01100	CAFETERIA	2,728,686	751,546	1,950	334,112	11.00
13.00	01300	NURSING ADMINISTRATION	1,446,592	43,228	0	295,560	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	837,538	167,609	638,111	7	14.00
15.00	01500	PHARMACY	3,822,247	157,993	399,685	681,370	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,077,478	176,192	0	245,232	16.00
17.00	01700	SOCIAL SERVICE	315,431	49,294	0	68,846	17.00
18.00	01850	OTHER GENERAL SERVICES	1,725,427	87,400	651	378,726	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,300,018	2,232,351	249,029	905,831	30.00
31.00	03100	INTENSIVE CARE UNIT	3,527,140	815,220	271,603	746,435	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,450,348	1,200,138	2,220,359	1,098,558	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,858,402	496,852	904,527	664,874	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,140,280	581,061	1,980,197	437,490	55.00
56.00	05600	RADIOISOTOPE	3,384,854	17,974	71,355	98,890	56.00
57.00	05700	CT SCAN	1,318,454	47,722	86,422	135,721	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	996,519	66,774	387,050	118,062	58.00
60.00	06000	LABORATORY	6,388,200	392,332	363,584	557,186	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,654,075	13,121	142,135	0	63.00
64.00	06400	INTRAVENOUS THERAPY	1,939,632	429,044	93,890	393,122	64.00
65.00	06500	RESPIRATORY THERAPY	1,359,269	8,088	14,936	247,036	65.00
66.00	06600	PHYSICAL THERAPY	1,468,939	235,372	6,552	322,780	66.00
69.00	06900	ELECTROCARDIOLOGY	495,227	24,040	87,699	97,006	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83,705,712	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	529,633	33,117	0	112,107	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9,644,951	1,863,700	125,651	2,149,914	90.00
91.00	09100	EMERGENCY	980,282	103,352	46,120	193,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	271,863,330	13,625,703	12,659,579	12,920,002	267,730,966
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190	47,362	0	0	190.00
191.00	19100	RESEARCH	34	54,642	953	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	29,757,042	2,869,628	218,170	941,609	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	301,620,596	16,597,335	12,878,702	13,861,611	301,620,596

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/27/2019 10:56 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	70,028,933					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	2,647,508	0	11,403,044			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	125,700	0	0	541,402		8.00
9.00	00900	HOUSEKEEPING	806,466	0	196,143	0	3,669,663	9.00
10.00	01000	DIETARY	121,305	0	34,019	0	11,146	10.00
11.00	01100	CAFETERIA	1,153,975	0	647,295	0	212,072	11.00
13.00	01300	NURSING ADMINISTRATION	539,865	0	37,232	0	12,198	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	496,892	0	144,359	0	47,296	14.00
15.00	01500	PHARMACY	1,530,439	0	136,077	0	44,583	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	453,239	0	151,752	0	49,718	16.00
17.00	01700	SOCIAL SERVICE	131,104	0	42,456	0	13,910	17.00
18.00	01850	OTHER GENERAL SERVICES	662,881	0	75,276	1,383	24,662	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,324,472	0	1,922,690	83,468	629,927	30.00
31.00	03100	INTENSIVE CARE UNIT	1,620,883	0	702,137	79,985	230,039	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,131,225	0	1,033,660	68,132	338,656	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,396,265	0	427,931	118,116	140,202	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,461,087	0	500,459	61,322	163,964	55.00
56.00	05600	RADIOISOTOPE	1,080,429	0	15,481	0	5,072	56.00
57.00	05700	CT SCAN	480,277	0	41,102	0	13,466	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	474,256	0	57,512	0	18,842	58.00
60.00	06000	LABORATORY	2,328,727	0	337,910	0	110,709	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	547,107	0	11,301	0	3,703	63.00
64.00	06400	INTRAVENOUS THERAPY	863,506	0	369,529	39,184	121,068	64.00
65.00	06500	RESPIRATORY THERAPY	492,678	0	6,966	24	2,282	65.00
66.00	06600	PHYSICAL THERAPY	614,935	0	202,723	13,031	66,418	66.00
69.00	06900	ELECTROCARDIOLOGY	212,868	0	20,706	8,123	6,784	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,311,033	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	204,064	0	28,524	0	9,345	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,168,085	0	1,605,177	60,541	525,900	90.00
91.00	09100	EMERGENCY	400,082	0	89,015	6,756	29,164	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)	59,781,353	0	8,837,432	540,065	2,831,126	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,379	0	40,792	0	13,365	190.00
191.00	19100	RESEARCH	16,821	0	47,062	0	15,419	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	10,216,380	0	2,477,758	1,337	809,753	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	70,028,933	0	11,403,044	541,402	3,669,663	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/27/2019 10:56 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	567,635					10.00
11.00	01100	CAFETERIA	0	5,829,636				11.00
13.00	01300	NURSING ADMINISTRATION	0	122,916	2,497,591			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,331,812		14.00
15.00	01500	PHARMACY	0	316,059	0	0	7,088,453	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	167,806	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	39,161	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICES	0	173,777	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	404,241	437,609	648,785	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	387,461	575,133	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	551,375	818,122	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	312,322	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	236,147	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	35,863	0	0	0	56.00
57.00	05700	CT SCAN	0	63,119	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	50,651	0	0	0	58.00
60.00	06000	LABORATORY	0	338,006	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	163,394	179,278	266,114	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	123,624	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	165,403	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	42,350	62,863	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,331,812	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	7,088,453	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	62,251	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,152,854	0	0	0	90.00
91.00	09100	EMERGENCY	0	85,271	126,574	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	567,635	5,043,303	2,497,591	2,331,812	7,088,453	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	786,333	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	567,635	5,829,636	2,497,591	2,331,812	7,088,453	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE S	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	18.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,321,417					16.00
17.00	01700	SOCIAL SERVICE	0	660,202				17.00
18.00	01850	OTHER GENERAL SERVICES	0	0	3,130,183			18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	37,391	10,640	50,412	14,236,864	0	30.00
31.00	03100	INTENSIVE CARE UNIT	25,505	7,258	34,388	9,023,187	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	201,664	57,389	271,896	25,441,522	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,818	28,690	135,929	11,584,928	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	138,113	39,304	186,212	11,925,636	0	55.00
56.00	05600	RADIOISOTOPE	21,768	6,195	29,349	4,767,230	0	56.00
57.00	05700	CT SCAN	154,914	44,085	208,865	2,594,147	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	38,289	10,896	51,623	2,270,474	0	58.00
60.00	06000	LABORATORY	139,022	39,563	187,438	11,182,677	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	17,951	5,108	24,202	2,418,703	0	63.00
64.00	06400	INTRAVENOUS THERAPY	54,312	15,456	73,226	5,000,755	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,984	3,695	17,506	2,289,088	0	65.00
66.00	06600	PHYSICAL THERAPY	7,254	2,064	9,781	3,115,252	0	66.00
69.00	06900	ELECTROCARDIOLOGY	11,895	3,385	16,038	1,088,984	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,688	3,895	18,455	2,367,850	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	1,314,542	373,669	1,772,653	119,566,062	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	2,736	779	3,689	986,245	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	23,417	6,664	31,572	21,358,426	0	90.00
91.00	09100	EMERGENCY	5,154	1,467	6,949	2,073,537	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,321,417	660,202	3,130,183	253,291,567	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	116,088	0	190.00
191.00	19100	RESEARCH	0	0	0	134,931	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	48,078,010	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,321,417	660,202	3,130,183	301,620,596	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
18.00	01850	OTHER GENERAL SERVICES	18.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	76.00
76.01	03951	HOSPITAL NUTRITION	76.01
76.02	03952	PAIN MANAGEMENT	76.02
76.03	03954	INFUSION CENTER	76.03
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
191.00	19100	RESEARCH	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0100

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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	91,624	2,433	94,057	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	844,069	3,955,103	4,799,172	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	2,429,259	406,808	2,836,067	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	227,733	27,910	255,643	9.00
10.00	01000	DIETARY	0	39,498	175,819	215,317	10.00
11.00	01100	CAFETERIA	0	751,546	1,950	753,496	11.00
13.00	01300	NURSING ADMINISTRATION	0	43,228	0	43,228	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	167,609	638,111	805,720	14.00
15.00	01500	PHARMACY	0	157,993	399,685	557,678	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	176,192	0	176,192	16.00
17.00	01700	SOCIAL SERVICE	0	49,294	0	49,294	17.00
18.00	01850	OTHER GENERAL SERVICES	0	87,400	651	88,051	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,232,351	249,029	2,481,380	30.00
31.00	03100	INTENSIVE CARE UNIT	0	815,220	271,603	1,086,823	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,200,138	2,220,359	3,420,497	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	496,852	904,527	1,401,379	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	581,061	1,980,197	2,561,258	55.00
56.00	05600	RADIOISOTOPE	0	17,974	71,355	89,329	56.00
57.00	05700	CT SCAN	0	47,722	86,422	134,144	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	66,774	387,050	453,824	58.00
60.00	06000	LABORATORY	0	392,332	363,584	755,916	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	13,121	142,135	155,256	63.00
64.00	06400	INTRAVENOUS THERAPY	0	429,044	93,890	522,934	64.00
65.00	06500	RESPIRATORY THERAPY	0	8,088	14,936	23,024	65.00
66.00	06600	PHYSICAL THERAPY	0	235,372	6,552	241,924	66.00
69.00	06900	ELECTROCARDIOLOGY	0	24,040	87,699	111,739	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	33,117	0	33,117	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	1,863,700	125,651	1,989,351	90.00
91.00	09100	EMERGENCY	0	103,352	46,120	149,472	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	13,625,703	12,659,579	26,285,282	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	47,362	0	47,362	190.00
191.00	19100	RESEARCH	0	54,642	953	55,595	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	2,869,628	218,170	3,087,798	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	16,597,335	12,878,702	29,476,037	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,812,018					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	181,923	0	3,020,335			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,637	0	0	8,711		8.00
9.00	00900	HOUSEKEEPING	55,416	0	51,953	0	365,532	9.00
10.00	01000	DIETARY	8,335	0	9,011	0	1,110	10.00
11.00	01100	CAFETERIA	79,295	0	171,450	0	21,124	11.00
13.00	01300	NURSING ADMINISTRATION	37,097	0	9,862	0	1,215	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	34,144	0	38,237	0	4,711	14.00
15.00	01500	PHARMACY	105,164	0	36,043	0	4,441	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,144	0	40,195	0	4,952	16.00
17.00	01700	SOCIAL SERVICE	9,009	0	11,245	0	1,386	17.00
18.00	01850	OTHER GENERAL SERVICES	45,550	0	19,938	22	2,457	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	159,725	0	509,265	1,343	62,746	30.00
31.00	03100	INTENSIVE CARE UNIT	111,378	0	185,976	1,287	22,914	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	352,590	0	273,787	1,096	33,733	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	164,658	0	113,346	1,900	13,965	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	169,113	0	132,557	987	16,332	55.00
56.00	05600	RADIOISOTOPE	74,241	0	4,100	0	505	56.00
57.00	05700	CT SCAN	33,002	0	10,887	0	1,341	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	32,588	0	15,233	0	1,877	58.00
60.00	06000	LABORATORY	160,018	0	89,502	0	11,028	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	37,594	0	2,993	0	369	63.00
64.00	06400	INTRAVENOUS THERAPY	59,335	0	97,878	630	12,059	64.00
65.00	06500	RESPIRATORY THERAPY	33,854	0	1,845	0	227	65.00
66.00	06600	PHYSICAL THERAPY	42,255	0	53,695	210	6,616	66.00
69.00	06900	ELECTROCARDIOLOGY	14,627	0	5,484	131	676	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,739,246	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	14,022	0	7,555	0	931	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	286,408	0	425,165	974	52,385	90.00
91.00	09100	EMERGENCY	27,491	0	23,578	109	2,905	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)	4,107,859	0	2,340,780	8,689	282,005	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	988	0	10,805	0	1,331	190.00
191.00	19100	RESEARCH	1,156	0	12,465	0	1,536	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	702,015	0	656,285	22	80,660	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,812,018	0	3,020,335	8,711	365,532	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	233,886					10.00
11.00	01100	CAFETERIA	0	1,027,632				11.00
13.00	01300	NURSING ADMINISTRATION	0	21,667	115,074			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	882,812		14.00
15.00	01500	PHARMACY	0	55,714	0	0	763,663	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,580	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	6,903	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICES	0	30,633	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	166,562	77,141	29,892	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	68,301	26,499	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	97,195	37,694	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	55,055	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	41,627	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	6,322	0	0	0	56.00
57.00	05700	CT SCAN	0	11,126	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,929	0	0	0	58.00
60.00	06000	LABORATORY	0	59,583	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	67,324	31,603	12,261	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	21,792	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	29,157	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	7,465	2,896	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	882,812	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	763,663	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	10,973	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	203,222	0	0	0	90.00
91.00	09100	EMERGENCY	0	15,031	5,832	0	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)	233,886	889,019	115,074	882,812	763,663	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	138,613	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	233,886	1,027,632	115,074	882,812	763,663	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE S	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	18.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	283,727					16.00
17.00	01700	SOCIAL SERVICE	0	78,304				17.00
18.00	01850	OTHER GENERAL SERVICES	0	0	189,221			18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,576	1,265	3,051	3,503,092	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,122	863	2,081	1,514,309	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,681	6,822	16,454	4,272,003	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,339	3,411	8,226	1,778,790	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	16,903	4,672	11,269	2,957,686	0	55.00
56.00	05600	RADIOISOTOPE	2,664	736	1,776	180,344	0	56.00
57.00	05700	CT SCAN	18,960	5,241	12,640	228,262	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,686	1,295	3,124	522,357	0	58.00
60.00	06000	LABORATORY	17,015	4,703	11,343	1,112,889	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,197	607	1,465	200,481	0	63.00
64.00	06400	INTRAVENOUS THERAPY	6,647	1,837	4,431	819,606	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,589	439	1,059	85,505	0	65.00
66.00	06600	PHYSICAL THERAPY	888	245	592	377,772	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,456	402	971	146,505	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,675	463	1,117	886,067	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	160,497	44,244	107,067	2,814,717	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	335	93	223	68,010	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,866	792	1,911	2,977,666	0	90.00
91.00	09100	EMERGENCY	631	174	421	226,956	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	283,727	78,304	189,221	24,673,017	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	60,486	0	190.00
191.00	19100	RESEARCH	0	0	0	70,752	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	4,671,782	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	283,727	78,304	189,221	29,476,037	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
18.00	01850	OTHER GENERAL SERVICES	18.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	76.00
76.01	03951	HOSPITAL NUTRITION	76.01
76.02	03952	PAIN MANAGEMENT	76.02
76.03	03954	INFUSION CENTER	76.03
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
191.00	19100	RESEARCH	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019

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Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	369,359					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		12,878,702				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,039	2,433	54,023,158			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,784	3,955,103	7,378,762	-70,028,933	231,591,663	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	54,061	406,808	1,346,764	0	8,755,536	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	42,236	0	415,702	8.00
9.00	00900	HOUSEKEEPING	5,068	27,910	1,447,584	0	2,667,054	9.00
10.00	01000	DIETARY	879	175,819	64,972	0	401,165	10.00
11.00	01100	CAFETERIA	16,725	1,950	1,302,144	0	3,816,294	11.00
13.00	01300	NURSING ADMINISTRATION	962	0	1,151,894	0	1,785,380	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	638,111	26	0	1,643,265	14.00
15.00	01500	PHARMACY	3,516	399,685	2,655,524	0	5,061,295	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,921	0	955,748	0	1,498,902	16.00
17.00	01700	SOCIAL SERVICE	1,097	0	268,314	0	433,571	17.00
18.00	01850	OTHER GENERAL SERVICES	1,945	651	1,476,019	0	2,192,204	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	49,679	249,029	3,530,320	0	7,687,229	30.00
31.00	03100	INTENSIVE CARE UNIT	18,142	271,603	2,909,101	0	5,360,398	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,708	2,220,359	4,281,441	0	16,969,403	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,057	904,527	2,591,233	0	7,924,655	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,931	1,980,197	1,705,042	0	8,139,028	55.00
56.00	05600	RADIOISOTOPE	400	71,355	385,408	0	3,573,073	56.00
57.00	05700	CT SCAN	1,062	86,422	528,948	0	1,588,319	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,486	387,050	460,128	0	1,568,405	58.00
60.00	06000	LABORATORY	8,731	363,584	2,171,536	0	7,701,302	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	292	142,135	0	0	1,809,331	63.00
64.00	06400	INTRAVENOUS THERAPY	9,548	93,890	1,532,127	0	2,855,688	64.00
65.00	06500	RESPIRATORY THERAPY	180	14,936	962,779	0	1,629,329	65.00
66.00	06600	PHYSICAL THERAPY	5,238	6,552	1,257,979	0	2,033,643	66.00
69.00	06900	ELECTROCARDIOLOGY	535	87,699	378,065	0	703,972	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	83,705,712	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	737	0	436,916	0	674,857	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	41,475	125,651	8,378,835	0	13,784,216	90.00
91.00	09100	EMERGENCY	2,300	46,120	753,552	0	1,323,105	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)	303,228	12,659,579	50,353,397	-70,028,933	197,702,033	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,054	0	0	0	47,552	190.00
191.00	19100	RESEARCH	1,216	953	0	0	55,629	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	63,861	218,170	3,669,761	0	33,786,449	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	16,597,335	12,878,702	13,861,611		70,028,933	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44.935510	1.000000	0.256586		0.302381	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			94,057		4,812,018	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001741		0.020778	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: 14-0100

Period:
From 07/01/2018
To 06/30/2019

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Date/Time Prepared:
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Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	348,536					6.00
7.00	00700	OPERATION OF PLANT	54,061	294,635				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	444,606			8.00
9.00	00900	HOUSEKEEPING	5,068	5,068	0	289,407		9.00
10.00	01000	DIETARY	879	879	0	879	27,490	10.00
11.00	01100	CAFETERIA	16,725	16,725	0	16,725	0	11.00
13.00	01300	NURSING ADMINISTRATION	962	962	0	962	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	3,730	0	3,730	0	14.00
15.00	01500	PHARMACY	3,516	3,516	0	3,516	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,921	3,921	0	3,921	0	16.00
17.00	01700	SOCIAL SERVICE	1,097	1,097	0	1,097	0	17.00
18.00	01850	OTHER GENERAL SERVICES	1,945	1,945	1,136	1,945	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	49,679	49,679	68,545	49,679	19,577	30.00
31.00	03100	INTENSIVE CARE UNIT	18,142	18,142	65,685	18,142	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,708	26,708	55,951	26,708	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,057	11,057	96,998	11,057	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,931	12,931	50,358	12,931	0	55.00
56.00	05600	RADIOISOTOPE	400	400	0	400	0	56.00
57.00	05700	CT SCAN	1,062	1,062	0	1,062	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,486	1,486	0	1,486	0	58.00
60.00	06000	LABORATORY	8,731	8,731	0	8,731	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	292	292	0	292	0	63.00
64.00	06400	INTRAVENOUS THERAPY	9,548	9,548	32,178	9,548	7,913	64.00
65.00	06500	RESPIRATORY THERAPY	180	180	20	180	0	65.00
66.00	06600	PHYSICAL THERAPY	5,238	5,238	10,701	5,238	0	66.00
69.00	06900	ELECTROCARDIOLOGY	535	535	6,671	535	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	737	737	0	737	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	41,475	41,475	49,717	41,475	0	90.00
91.00	09100	EMERGENCY	2,300	2,300	5,548	2,300	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)	282,405	228,344	443,508	223,276	27,490	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,054	1,054	0	1,054	0	190.00
191.00	19100	RESEARCH	1,216	1,216	0	1,216	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	63,861	64,021	1,098	63,861	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	11,403,044	541,402	3,669,663	567,635	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	38.702272	1.217712	12.679939	20.648781	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	3,020,335	8,711	365,532	233,886	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	10.251107	0.019593	1.263038	8.508039	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: 14-0100

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAFETERIA (ASSIGNED TIME)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,276,045					11.00
13.00	01300	NURSING ADMINISTRATION	26,905	368,303				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,000			14.00
15.00	01500	PHARMACY	69,182	0	0	1,000		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,731	0	0	0	1,154,865,221	16.00
17.00	01700	SOCIAL SERVICE	8,572	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICES	38,038	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	95,788	95,672	0	0	18,602,264	30.00
31.00	03100	INTENSIVE CARE UNIT	84,811	84,811	0	0	12,689,147	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	120,690	120,643	0	0	100,330,546	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,364	0	0	0	50,158,131	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	51,690	0	0	0	68,712,955	55.00
56.00	05600	RADIOISOTOPE	7,850	0	0	0	10,830,040	56.00
57.00	05700	CT SCAN	13,816	0	0	0	77,071,779	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,087	0	0	0	19,049,005	58.00
60.00	06000	LABORATORY	73,986	0	0	0	69,165,387	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	8,930,667	63.00
64.00	06400	INTRAVENOUS THERAPY	39,242	39,242	0	0	27,020,648	64.00
65.00	06500	RESPIRATORY THERAPY	27,060	0	0	0	6,459,910	65.00
66.00	06600	PHYSICAL THERAPY	36,205	0	0	0	3,609,194	66.00
69.00	06900	ELECTROCARDIOLOGY	9,270	9,270	0	0	5,917,904	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,000	0	6,809,939	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	1,000	653,932,108	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	13,626	0	0	0	1,361,223	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	252,347	0	0	0	11,650,085	90.00
91.00	09100	EMERGENCY	18,665	18,665	0	0	2,564,289	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)	1,103,925	368,303	1,000	1,000	1,154,865,221	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	172,120	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,829,636	2,497,591	2,331,812	7,088,453	2,321,417	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.568519	6.781349	2,331.812000	7,088.453000	0.002010	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,027,632	115,074	882,812	763,663	283,727	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.805326	0.312444	882.812000	763.663000	0.000246	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: 14-0100

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		SOCIAL SERVICE (GROSS CHARGES)	OTHER GENERAL SERVICE S (GROSS CHARGES)	
		17.00	18.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	1,154,865,221	17.00
18.00	01850	OTHER GENERAL SERVICES	0 1,154,865,221	18.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	18,602,264	30.00
31.00	03100	INTENSIVE CARE UNIT	12,689,147	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	100,330,546	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,158,131	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	68,712,955	55.00
56.00	05600	RADIOISOTOPE	10,830,040	56.00
57.00	05700	CT SCAN	77,071,779	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	19,049,005	58.00
60.00	06000	LABORATORY	69,165,387	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	8,930,667	63.00
64.00	06400	INTRAVENOUS THERAPY	27,020,648	64.00
65.00	06500	RESPIRATORY THERAPY	6,459,910	65.00
66.00	06600	PHYSICAL THERAPY	3,609,194	66.00
69.00	06900	ELECTROCARDIOLOGY	5,917,904	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,809,939	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	653,932,108	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	76.00
76.01	03951	HOSPITAL NUTRITION	1,361,223	76.01
76.02	03952	PAIN MANAGEMENT	0	76.02
76.03	03954	INFUSION CENTER	0	76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	11,650,085	90.00
91.00	09100	EMERGENCY	2,564,289	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)	1,154,865,221 1,154,865,221	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100	RESEARCH	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	660,202 3,130,183	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000572 0.002710	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	78,304 189,221	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000068 0.000164	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

Worksheet C
Part I
Date/Time Prepared:
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MCRIF32 - 15.9.167.1

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
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			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	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,999,783		15,999,783			30.00	
31.00	03100	INTENSIVE CARE UNIT	12,689,147		12,689,147			31.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	45,235,865	55,094,681	100,330,546	0.253577	0.000000	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,203,594	43,954,537	50,158,131	0.230968	0.000000	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	2,491,910	66,221,045	68,712,955	0.173557	0.000000	55.00	
56.00	05600	RADIOISOTOPE	228,527	10,601,513	10,830,040	0.440186	0.000000	56.00	
57.00	05700	CT SCAN	3,887,107	73,184,672	77,071,779	0.033659	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,450,212	17,598,793	19,049,005	0.119191	0.000000	58.00	
60.00	06000	LABORATORY	13,568,071	55,597,316	69,165,387	0.161680	0.000000	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,432,950	3,497,717	8,930,667	0.270831	0.000000	63.00	
64.00	06400	INTRAVENOUS THERAPY	112,808	26,907,840	27,020,648	0.185072	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	3,098,108	3,361,802	6,459,910	0.354353	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	1,579,516	2,029,678	3,609,194	0.863143	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	1,066,251	4,851,653	5,917,904	0.184015	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,532,900	2,277,039	6,809,939	0.347705	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	66,939,117	586,992,991	653,932,108	0.182842	0.000000	73.00	
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00	
76.01	03951	HOSPITAL NUTRITION	184,986	1,176,237	1,361,223	0.724529	0.000000	76.01	
76.02	03952	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	76.02	
76.03	03954	INFUSION CENTER	0	0	0	0.000000	0.000000	76.03	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	233,270	11,416,815	11,650,085	1.833328	0.000000	90.00	
91.00	09100	EMERGENCY	909,634	1,654,655	2,564,289	0.808621	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,044,593	1,557,888	2,602,481	1.118604	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	186,888,349	967,976,872	1,154,865,221			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	186,888,349	967,976,872	1,154,865,221			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
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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
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.253577			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230968			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.173557			55.00
56.00	05600	RADIOISOTOPE	0.440186			56.00
57.00	05700	CT SCAN	0.033659			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.119191			58.00
60.00	06000	LABORATORY	0.161680			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.270831			63.00
64.00	06400	INTRAVENOUS THERAPY	0.185072			64.00
65.00	06500	RESPIRATORY THERAPY	0.354353			65.00
66.00	06600	PHYSICAL THERAPY	0.863143			66.00
69.00	06900	ELECTROCARDIOLOGY	0.184015			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.347705			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.182842			73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000			76.00
76.01	03951	HOSPITAL NUTRITION	0.724529			76.01
76.02	03952	PAIN MANAGEMENT	0.000000			76.02
76.03	03954	INFUSION CENTER	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.833328			90.00
91.00	09100	EMERGENCY	0.808621			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.118604			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: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,236,864		14,236,864	0	14,236,864	30.00
31.00	03100	INTENSIVE CARE UNIT	9,023,187		9,023,187	0	9,023,187	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	25,441,522		25,441,522	0	25,441,522	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,584,928		11,584,928	0	11,584,928	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,925,636		11,925,636	0	11,925,636	55.00
56.00	05600	RADIOISOTOPE	4,767,230		4,767,230	0	4,767,230	56.00
57.00	05700	CT SCAN	2,594,147		2,594,147	0	2,594,147	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,270,474		2,270,474	0	2,270,474	58.00
60.00	06000	LABORATORY	11,182,677		11,182,677	0	11,182,677	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,418,703		2,418,703	0	2,418,703	63.00
64.00	06400	INTRAVENOUS THERAPY	5,000,755		5,000,755	0	5,000,755	64.00
65.00	06500	RESPIRATORY THERAPY	2,289,088	0	2,289,088	0	2,289,088	65.00
66.00	06600	PHYSICAL THERAPY	3,115,252	0	3,115,252	0	3,115,252	66.00
69.00	06900	ELECTROCARDIOLOGY	1,088,984		1,088,984	0	1,088,984	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,367,850		2,367,850	0	2,367,850	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	119,566,062		119,566,062	0	119,566,062	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	986,245		986,245	0	986,245	76.01
76.02	03952	PAIN MANAGEMENT	0		0	0	0	76.02
76.03	03954	INFUSION CENTER	0		0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	21,358,426		21,358,426	0	21,358,426	90.00
91.00	09100	EMERGENCY	2,073,537		2,073,537	0	2,073,537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,911,145		2,911,145		2,911,145	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	256,202,712	0	256,202,712	0	256,202,712	200.00
201.00		Less Observation Beds	2,911,145		2,911,145		2,911,145	201.00
202.00		Total (see instructions)	253,291,567	0	253,291,567	0	253,291,567	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/27/2019 10:56 am

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,999,783		15,999,783			30.00
31.00	03100	INTENSIVE CARE UNIT	12,689,147		12,689,147			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	45,235,865	55,094,681	100,330,546	0.253577	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,203,594	43,954,537	50,158,131	0.230968	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,491,910	66,221,045	68,712,955	0.173557	0.000000	55.00
56.00	05600	RADIOISOTOPE	228,527	10,601,513	10,830,040	0.440186	0.000000	56.00
57.00	05700	CT SCAN	3,887,107	73,184,672	77,071,779	0.033659	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,450,212	17,598,793	19,049,005	0.119191	0.000000	58.00
60.00	06000	LABORATORY	13,568,071	55,597,316	69,165,387	0.161680	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,432,950	3,497,717	8,930,667	0.270831	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	112,808	26,907,840	27,020,648	0.185072	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,098,108	3,361,802	6,459,910	0.354353	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,579,516	2,029,678	3,609,194	0.863143	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,066,251	4,851,653	5,917,904	0.184015	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,532,900	2,277,039	6,809,939	0.347705	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,939,117	586,992,991	653,932,108	0.182842	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	184,986	1,176,237	1,361,223	0.724529	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0.000000	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	233,270	11,416,815	11,650,085	1.833328	0.000000	90.00
91.00	09100	EMERGENCY	909,634	1,654,655	2,564,289	0.808621	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,044,593	1,557,888	2,602,481	1.118604	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	186,888,349	967,976,872	1,154,865,221			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	186,888,349	967,976,872	1,154,865,221			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/27/2019 10:56 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000			76.00
76.01	03951	HOSPITAL NUTRITION	0.000000			76.01
76.02	03952	PAIN MANAGEMENT	0.000000			76.02
76.03	03954	INFUSION CENTER	0.000000			76.03
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: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part I
Date/Time Prepared:
11/27/2019 10:56 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,503,092	0	3,503,092	4,822	726.48	30.00
31.00	INTENSIVE CARE UNIT	1,514,309		1,514,309	4,283	353.56	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
200.00	Total (lines 30 through 199)	5,017,401		5,017,401	9,105		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	791	574,646				30.00
31.00	INTENSIVE CARE UNIT	1,089	385,027				31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				34.00
200.00	Total (lines 30 through 199)	1,880	959,673				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/27/2019 10:56 am

Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,272,003	100,330,546	0.042579	9,387,800	399,723
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,778,790	50,158,131	0.035464	1,501,928	53,264
55.00	05500	RADIOLOGY-THERAPEUTIC	2,957,686	68,712,955	0.043044	734,070	31,597
56.00	05600	RADIOISOTOPE	180,344	10,830,040	0.016652	97,143	1,618
57.00	05700	CT SCAN	228,262	77,071,779	0.002962	1,087,199	3,220
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	522,357	19,049,005	0.027422	414,977	11,379
60.00	06000	LABORATORY	1,112,889	69,165,387	0.016090	3,120,683	50,212
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	200,481	8,930,667	0.022449	1,000,340	22,457
64.00	06400	INTRAVENOUS THERAPY	819,606	27,020,648	0.030333	7,883	239
65.00	06500	RESPIRATORY THERAPY	85,505	6,459,910	0.013236	1,021,356	13,519
66.00	06600	PHYSICAL THERAPY	377,772	3,609,194	0.104669	488,375	51,118
69.00	06900	ELECTROCARDIOLOGY	146,505	5,917,904	0.024756	366,150	9,064
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	886,067	6,809,939	0.130114	1,069,577	139,167
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,814,717	653,932,108	0.004304	11,227,164	48,322
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0
76.01	03951	HOSPITAL NUTRITION	68,010	1,361,223	0.049962	43,764	2,187
76.02	03952	PAIN MANAGEMENT	0	0	0.000000	0	0
76.03	03954	INFUSION CENTER	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,977,666	11,650,085	0.255592	30,808	7,874
91.00	09100	EMERGENCY	226,956	2,564,289	0.088506	255,504	22,614
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	716,311	2,602,481	0.275242	279,394	76,901
200.00		Total (lines 50 through 199)	20,371,927	1,126,176,291		32,134,115	944,475

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0100		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 11/27/2019 10:56 am	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	0	34.00
200.00		Total (lines 30 through 199)	0	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	4,822	0.00	791	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	4,283	0.00	1,089	31.00		
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	0	34.00		
200.00		Total (lines 30 through 199)	0	0	9,105		1,880	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
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0							34.00
200.00		Total (lines 30 through 199)	0							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0100

Period:
From 07/01/2018
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Part IV
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Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/27/2019 10:56 am

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	100,330,546	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	50,158,131	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	68,712,955	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	10,830,040	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	77,071,779	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	19,049,005	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	69,165,387	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	8,930,667	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	27,020,648	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,459,910	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,609,194	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,917,904	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,809,939	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	653,932,108	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	0	0	0	1,361,223	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	11,650,085	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	2,564,289	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,602,481	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	1,126,176,291		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
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Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	9,387,800	0	9,627,974	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,501,928	0	8,135,196	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	734,070	0	16,856,610	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	97,143	0	1,476,234	0	56.00
57.00	05700	CT SCAN	0.000000	1,087,199	0	17,181,072	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	414,977	0	3,835,641	0	58.00
60.00	06000	LABORATORY	0.000000	3,120,683	0	10,259,298	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	1,000,340	0	734,009	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	7,883	0	5,328,408	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,021,356	0	827,317	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	488,375	0	73,858	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	366,150	0	1,064,213	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,069,577	0	275,029	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	11,227,164	0	135,254,254	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0.000000	43,764	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	30,808	0	2,360,505	0	90.00
91.00	09100	EMERGENCY	0.000000	255,504	0	290,984	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	279,394	0	252,198	0	92.00
200.00		Total (lines 50 through 199)		32,134,115	0	213,832,800	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/27/2019 10:56 am

			Title XVIII		Hospital		PPS	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.253577	9,627,974	0	0	2,441,433	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230968	8,135,196	0	0	1,878,970	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.173557	16,856,610	0	0	2,925,583	55.00
56.00	05600	RADIOISOTOPE	0.440186	1,476,234	0	0	649,818	56.00
57.00	05700	CT SCAN	0.033659	17,181,072	0	0	578,298	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.119191	3,835,641	0	0	457,174	58.00
60.00	06000	LABORATORY	0.161680	10,259,298	0	0	1,658,723	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.270831	734,009	0	0	198,792	63.00
64.00	06400	INTRAVENOUS THERAPY	0.185072	5,328,408	0	0	986,139	64.00
65.00	06500	RESPIRATORY THERAPY	0.354353	827,317	0	0	293,162	65.00
66.00	06600	PHYSICAL THERAPY	0.863143	73,858	0	0	63,750	66.00
69.00	06900	ELECTROCARDIOLOGY	0.184015	1,064,213	0	0	195,831	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.347705	275,029	0	0	95,629	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	0.182842	135,254,254	0	287,105	24,730,158	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0.724529	0	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1.833328	2,360,505	0	1,027	4,327,580	90.00
91.00	09100	EMERGENCY	0.808621	290,984	0	0	235,296	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.118604	252,198	0	0	282,110	92.00
200.00		Subtotal (see instructions)		213,832,800	0	288,132	41,998,446	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		213,832,800	0	288,132	41,998,446	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/27/2019 10:56 am

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	52,495		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	0	0		76.01
76.02	03952	PAIN MANAGEMENT	0	0		76.02
76.03	03954	INFUSION CENTER	0	0		76.03
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	1,883		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	54,378		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	54,378		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0100	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/27/2019 10:56 am
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,822	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,822	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,836	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)		791	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		14,236,864	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		14,236,864	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		14,236,864	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)		2,952.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,335,412	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,335,412	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019

Worksheet D-1

Date/Time Prepared:
11/27/2019 10:56 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,023,187	4,283	2,106.74	1,089	2,294,240	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					7,643,436	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					12,273,088	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)					959,673	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					944,475	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,904,148	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,368,940	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)					986	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,952.48	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,911,145	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019

Worksheet D-1

Date/Time Prepared:
11/27/2019 10:56 am

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,503,092	14,236,864	0.246058	2,911,145	716,311
91.00	Nursing School cost	0	14,236,864	0.000000	2,911,145	0
92.00	Allied health cost	0	14,236,864	0.000000	2,911,145	0
93.00	All other Medical Education	0	14,236,864	0.000000	2,911,145	0

Health Financial Systems		MIDWESTERN REGIONAL MEDICAL CENTER		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0100	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/27/2019 10:56 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,627,286	30.00
31.00	03100	INTENSIVE CARE UNIT		3,419,904	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.253577	9,387,800	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230968	1,501,928	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.173557	734,070	55.00
56.00	05600	RADIOISOTOPE	0.440186	97,143	56.00
57.00	05700	CT SCAN	0.033659	1,087,199	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.119191	414,977	58.00
60.00	06000	LABORATORY	0.161680	3,120,683	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.270831	1,000,340	63.00
64.00	06400	INTRAVENOUS THERAPY	0.185072	7,883	64.00
65.00	06500	RESPIRATORY THERAPY	0.354353	1,021,356	65.00
66.00	06600	PHYSICAL THERAPY	0.863143	488,375	66.00
69.00	06900	ELECTROCARDIOLOGY	0.184015	366,150	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.347705	1,069,577	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.182842	11,227,164	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.00
76.01	03951	HOSPITAL NUTRITION	0.724529	43,764	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.833328	30,808	90.00
91.00	09100	EMERGENCY	0.808621	255,504	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.118604	279,394	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		32,134,115	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		32,134,115	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A
Date/Time Prepared:
11/27/2019 10:56 am

		Title XVIII	Hospital	PPS	
		1.00			
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0	1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		815,571	1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,860,324	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)		3,155,083	2.00	
2.01	Outlier reconciliation amount		0	2.01	
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02	
3.00	Managed Care Simulated Payments		0	3.00	
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		70.30	4.00	
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00	
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00	
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00	
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01	
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00	
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01	
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02	
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00	
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00	
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00	
12.00	Current year allowable FTE (see instructions)		0.00	12.00	
13.00	Total allowable FTE count for the prior year.		0.00	13.00	
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00	
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00	
16.00	Adjustment for residents in initial years of the program		0.00	16.00	
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00	
18.00	Adjusted rolling average FTE count		0.00	18.00	
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00	
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00	
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00	
22.00	IME payment adjustment (see instructions)		0	22.00	
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01	
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00	
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00	
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00	
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00	
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00	
28.00	IME add-on adjustment amount (see instructions)		0	28.00	
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01	
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01	
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00	30.00	
31.00	Percentage of Medicaid patient days (see instructions)		0.00	31.00	
32.00	Sum of lines 30 and 31		0.00	32.00	
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00	
34.00	Disproportionate share adjustment (see instructions)		0	34.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0100	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/27/2019 10:56 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)	6,830,978			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
			Amount		
			1.00		
49.00	Total payment for inpatient operating costs (see instructions)		6,830,978		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		874,764		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)		7,705,742		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		7,705,742		61.00
62.00	Deductibles billed to program beneficiaries		279,780		62.00
63.00	Coinsurance billed to program beneficiaries		15,686		63.00
64.00	Allowable bad debts (see instructions)		41,671		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		27,086		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,340		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		7,437,362		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)		13,234		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: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A
Date/Time Prepared:
11/27/2019 10:56 am

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			60,010	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			7,390,586	71.00
71.01	Sequestration adjustment (see instructions)			147,812	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			7,231,197	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)			11,577	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	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000		103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/27/2019 10:56 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	815,571	815,571		815,571	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,860,324		2,860,324	2,860,324	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	3,155,083	829,449	2,325,634	3,155,083	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,830,978	1,645,020	5,185,958	6,830,978	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,830,978	1,645,020	5,185,958	6,830,978	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	874,764	66,915	807,849	874,764	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			1,711,935	5,993,807	7,705,742	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/27/2019 10:56 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	299,124	55,376	243,748	299,124	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	575,640	11,539	564,101	575,640	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	874,764	66,915	807,849	874,764	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	13,234	6,059	7,175	13,234	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	60,010	60,010	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0100	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/27/2019 10:56 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		54,378	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		41,998,446	2.00
3.00	OPPS payments		25,785,838	3.00
4.00	Outlier payment (see instructions)		1,067,464	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)		54,378	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		288,132	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)		288,132	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)		288,132	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		233,754	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)		54,378	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)		26,853,302	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)		3,952,627	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)		22,955,053	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)		22,955,053	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		22,955,053	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)		654,475	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		425,409	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		22,038	36.00
37.00	Subtotal (see instructions)		23,380,462	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		23,380,462	40.00
40.01	Sequestration adjustment (see instructions)		467,609	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		22,631,763	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		281,090	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/27/2019 10:56 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		7,231,197		22,631,763	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,231,197		22,631,763	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		11,577		281,090	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		7,242,774		22,912,853	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: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part II
Date/Time Prepared:
11/27/2019 10:56 am

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

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

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019

Worksheet G

Date/Time Prepared:

11/27/2019 10:56 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	0	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	0	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	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)	0	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	0	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	0	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	0	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	0	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	0	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	0				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	0	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	0	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019

Worksheet G-1

Date/Time Prepared:
11/27/2019 10:56 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-395,398,053				2.00
3.00	Total (sum of line 1 and line 2)		-395,398,053		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)		-395,398,053		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-395,398,053		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/27/2019 10:56 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	0		0	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	0		0	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	0		0	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	0	0	0	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		395,398,053		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)		395,398,053		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0100

Period:
From 07/01/2018
To 06/30/2019

Worksheet G-3

Date/Time Prepared:
11/27/2019 10:56 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	0	1.00
2.00	Less contractual allowances and discounts on patients' accounts	0	2.00
3.00	Net patient revenues (line 1 minus line 2)	0	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	395,398,053	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-395,398,053	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	0	25.00
26.00	Total (line 5 plus line 25)	-395,398,053	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-395,398,053	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0100	Period: From 07/01/2018 To 06/30/2019	Worksheet L Parts I-III Date/Time Prepared: 11/27/2019 10:56 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		299,124	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		575,640	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)		22.24	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)		874,764	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